

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0003103

Facility Name: Memorial Care Center

Address: 4315 Memorial Drive Belleville 62226
Number City Zip Code

County: St Clair

Telephone Number: (618) 233-7750 Fax # (618) 257-6931

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Melinda Hernandez Telephone Number: (605) 251-4629
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
State of Illinois, for the period from 1/1/2020 to 12/31/2020
and certify to the best of my knowledge and belief that the said contents
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than provider)
is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information
in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Jane Gusmano
(Title) VP - Finance

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Memorial Care Center

0003103 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)	82	29,930	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	82	29,930	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11		18,594	18,605	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11		18,594	18,605	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.16%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 03/03/1964

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 82 and days of care provided _____

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 1/1/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	249,815		67,239	317,054	(67,239)	249,815		249,815			1
2	Food Purchase		136,169		136,169		136,169		136,169			2
3	Housekeeping	135,770	52,977	31,216	219,963	(82,456)	137,507		137,507			3
4	Laundry			51,239	51,239		51,239	148,354	199,593			4
5	Heat and Other Utilities			107,965	107,965		107,965		107,965			5
6	Maintenance	82,358	1,073	64,794	148,225	(3,396)	144,829		144,829			6
7	Other (specify):*											7
8	TOTAL General Services	467,943	190,219	322,453	980,615	(153,091)	827,524	148,354	975,878			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,559,961	325,886	1,502,677	4,388,524	(1,184,397)	3,204,127	614,369	3,818,496			10
10a	Therapy	1,554,480	9,983	398,237	1,962,700	(397,860)	1,564,840	2,347,364	3,912,204			10a
11	Activities	78,202	5,849	32,440	116,491	(27,008)	89,483		89,483			11
12	Social Services	88,056	357	15,909	104,322	(15,116)	89,206		89,206			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,280,699	342,075	1,949,263	6,572,037	(1,624,381)	4,947,656	2,961,733	7,909,389			16
	C. General Administration											
17	Administrative	137,294			137,294	(1,355)	135,939		135,939			17
18	Directors Fees											18
19	Professional Services					146,830	146,830		146,830			19
20	Dues, Fees, Subscriptions & Promotions					1,520	1,520		1,520			20
21	Clerical & General Office Expenses	1,960,653	13,335	7,286	1,981,274		1,981,274	2,049,995	4,031,269			21
22	Employee Benefits & Payroll Taxes					1,653,450	1,653,450	63,546	1,716,996			22
23	Inservice Training & Education			1,563	1,563	2,028	3,591		3,591			23
24	Travel and Seminar			465	465		465		465			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,835	43,835		43,835		43,835			26
27	Other (specify):*											27
28	TOTAL General Administration	2,097,947	13,335	53,149	2,164,431	1,802,473	3,966,904	2,113,541	6,080,445			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,846,589	545,629	2,324,865	9,717,083	25,001	9,742,084	5,223,628	14,965,712			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			366,289	366,289		366,289	(19,468)	346,821			30
31	Amortization of Pre-Op. & Org.			312	312		312		312			31
32	Interest			130,049	130,049		130,049	(130,048)	1			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			125,435	125,435		125,435		125,435			35
36	Other (specify):*											36
37	TOTAL Ownership			622,085	622,085		622,085	(149,516)	472,569			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,731	2,731		2,731		2,731			38
39	Ancillary Service Centers	203,387	402,824	148,008	754,219	(25,001)	729,218	138,310	867,528			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*							321,315	321,315			43
44	TOTAL Special Cost Centers	203,387	402,824	150,739	756,950	(25,001)	731,949	459,625	1,191,574			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,049,976	948,453	3,097,689	11,096,118		11,096,118	5,533,737	16,629,855			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Memorial Care Center

ID#	0003103
Report Period Beginning:	1/1/2020
Ending:	12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
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26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Memorial Care Center# 0003103

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	148,354	0	0	0	0	0	0	0	0	0	148,354	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	148,354	0	0	0	0	0	0	0	0	0	148,354	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	614,369	0	0	0	0	0	0	0	0	0	614,369	10
10a	Therapy	0	2,347,364	0	0	0	0	0	0	0	0	0	2,347,364	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	2,961,733	0	0	0	0	0	0	0	0	0	2,961,733	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	2,049,995	0	0	0	0	0	0	0	0	0	2,049,995	21
22	Employee Benefits & Payroll Taxes	0	63,546	0	0	0	0	0	0	0	0	0	63,546	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	2,113,541	0	0	0	0	0	0	0	0	0	2,113,541	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	5,223,628	0	0	0	0	0	0	0	0	0	5,223,628	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	(19,468)	0	0	0	0	0	0	0	0	0	(19,468)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(130,048)	0	0	0	0	0	0	0	0	0	(130,048)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	(149,516)	0	0	0	0	0	0	0	0	0	(149,516)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	138,310	0	0	0	0	0	0	0	0	0	138,310	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	321,315	0	0	0	0	0	0	0	0	0	321,315	43
44	TOTAL Special Cost Centers	0	459,625	0	0	0	0	0	0	0	0	0	459,625	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	5,533,737	0	0	0	0	0	0	0	0	0	5,533,737	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Memorial Hospital	Belleville	Hospital

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	39	Radiology, CT, Lab, RT, Cardio,	\$ 329,919	Memorial Hospital Belleville	100.00%	\$ 468,229	\$ 138,310	1
2	V	10a	Therapies	1,993,665			4,341,029	2,347,364	2
3	V	43	Pharmacy	684,532			1,005,847	321,315	3
4	V	32	Allowable Interest Expense	130,049			1	(130,048)	4
5	V	30	Depreciation	417,555			398,087	(19,468)	5
6	V	21	A&G Overhead Allocation from Hospit	1			2,049,996	2,049,995	6
7	V	4	Laundry Overhead Allocation from Ho	1			148,355	148,354	7
8	V	22	Employee Meals from Hospital	1			63,547	63,546	8
9	V	10	Nursing Adm and Med Rec Overhead /	1			614,370	614,369	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 3,555,724			\$ 9,089,461	\$ * 5,533,737	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

Memorial Care Center

0003103

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Kevin Barnett	BOD						1
2	Geri Boyer	BOD						2
3	Keith Cook	BOD						3
4	Rev. Robert Dryer	BOD						4
5	Chris Eckert	BOD						5
6	Susan Gasser	BOD						6
7	Edward Hoering	BOD						7
8	Rachel Jackson	BOD						8
9	Jean Jospsh	BOD						9
10	Michael McManus	BOD						10
11	Hans Moosa	BOD						11
12	Staci Oliver	BOD						12
13	Beatriz Ramos-Pardo	BOD						13
14	Kurt Schroeder	BOD						14
15	Ronald Stephens	BOD						15
16	Valerie Thaxton	BOD						16
17	Mathra Weld	BOD						17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Memorial Care Center # 0003103 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NA								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Memorial Care Center# 0003103

Report Period Beginning:

1/1/2020Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Memorial Hospital Belleville

Street Address

4500 Memoiral Drive

City / State / Zip Code

Belleville, IL 62226

Phone Number

()

Fax Number

()

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
1	39	Radiology	Revenue	43,855,859	1	\$ 5,869,238	\$ 2,115,655	206,242	\$ 27,601	1
2	39	CT Scan	Revenue	73,369,015	1	1,985,939	759,640	5,854	158	2
3	39	Laboratory	Revenue	123,269,457	1	8,987,693	3,601,816	3,855,202	281,086	3
4	39	Respiratory Therapy	Revenue	37,801,283	1	3,893,117	1,750,261	1,447,650	149,092	4
5	39	Cardiology	Revenue	54,223,207	1	3,049,799	1,432,411	155,836	8,765	5
6	39	MRI	Revenue	20,871,043	1	959,794	291,612	34,368	1,580	6
7	10a	Physical Therapy	Revenue	35,016,294	1	8,541,613	4,039,802	9,940,383	2,424,783	7
8	10a	Occupational Therapy	Revenue	11,672,945	1	2,278,656	1,194,194	6,886,259	1,344,255	8
9	10a	Speech Therapy	Revenue	2,354,058	1	1,341,248	663,671	1,006,338	573,371	9
10	43	Drugs	Revenue	118,151,284	1	19,104,800	3,558,111	6,218,012	1,005,439	10
11	32	Interest Expense	Actual	0	1			0		11
12	30	Depreciation	Actual	10,626,869	1	15,194,726	0	417,555	597,037	12
13	21	Communications	Phones	1,763	1	292,006	194,406	51	8,447	13
14	21	Data Processing	Resources	9,154	1	7,999,409	0	376	328,575	14
15	21	Purchasing	Requisitions	1,129,232	1	67,631	0	54,088	3,239	15
16	21	Admitting	Patient Days	64,475	1	1,129,232	832,017	18,605	325,853	16
17	21	Patient Accounts	Gross Charges	943,279,333	1	315,102	0	5,802,081	1,938	17
18	21	Admin & General	Acc. Cost	178,108,627	1	41,228,963	9,158,920	8,551,154	1,979,439	18
19	4	Laundry	Pounds	830,797	1	1,106,866	0	111,302	148,287	19
20	22	Cafeteria Employee Meals	Employee Meals	81,014	1	803,952	144,146	6,403	63,541	20
21	10	Nursing Admin	Time Spent	739,797	1	5,782,294	2,583,603	53,776	420,316	21
22	10	Medical Records	Time Spent	4,627	1	1,083,106	212,338	830	194,290	22
23										23
24										24
25	TOTALS					\$ 131,015,184	\$ 32,532,603		\$ 9,887,092	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	All Interest Expense is Eliminated			All Interest Expense is Eliminated			\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015		8	
	2016		9	
	2017		10	
	2018		11	
	2019		12	
		FOR BHF USE ONLY		
		13	FROM R. E. TAX STATEMENT FOR 2019 \$	13
		14	PLUS APPEAL COST FROM LINE 5 \$	14
		15	LESS REFUND FROM LINE 6 \$	15
		16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME Memorial Care Center COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0003103

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

PLEASE NOTE: *Payment information from the Internet* or otherwise is **not considered acceptable tax bill documentation** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

A. Square Feet: 33,325

B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1964	\$ 87,734	1
2					2
3	TOTALS			\$ 87,734	3

Facility Name & ID Number Memorial Care Center

0003103

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	4315 Memorial Dr		1/1/2016		272,561	13,628	240	13,628		68,140
10	4315 Memorial Dr		1/1/2016		1,108	55	240	55		277
11	4315 Memorial Dr		1/1/2016		739	37	240	37		185
12	4315 Memorial Dr		1/1/2016		1,114	56	240	56		278
13	4315 Memorial Dr		1/1/2016		30,839	1,542	240	1,542		7,710
14	4315 Memorial Dr		1/1/2016		3,061	153	240	153		765
15	4315 Memorial Dr		1/1/2016		1,067	53	240	53		267
16	4315 Memorial Dr		1/1/2016		115	6	240	6		29
17	4315 Memorial Dr		1/1/2016		99	5	240	5		25
18	4315 Memorial Dr		1/1/2016		61	3	240	3		15
19	4315 Memorial Dr		1/1/2016		82	4	240	4		21
20	4315 Memorial Dr		1/1/2016		57	3	240	3		14
21	4315 Memorial Dr		1/1/2016		134	7	240	7		34
22	4315 Memorial Dr		1/1/2016		154	8	240	8		39
23	4315 Memorial Dr		1/1/2016		164	8	240	8		41
24	4315 Memorial Dr		1/1/2016		505	25	240	25		126
25	4315 Memorial Dr		1/1/2016		86	4	240	4		22
26	4315 Memorial Dr		1/1/2016		445	22	240	22		111
27	4315 Memorial Dr		1/1/2016		108	5	240	5		27
28	4315 Memorial Dr		1/1/2016		221	11	240	11		55
29	4315 Memorial Dr		1/1/2016		121	6	240	6		30
30	4315 Memorial Dr		1/1/2016		1,033	52	240	52		258
31	4315 Memorial Dr		1/1/2016		1,375	69	240	69		344
32	4315 Memorial Dr		1/1/2016		33,436	1,672	240	1,672		8,359
33	4315 Memorial Dr		1/1/2016		14,224	711	240	711		3,556
34	4315 Memorial Dr		1/1/2016		8,770	439	240	439		2,193
35	4315 Memorial Dr		1/1/2016		690	35	240	35		173
36	4315 Memorial Dr		1/1/2016		811	41	240	41		203

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Memorial Care Center

0003103

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost		5 Current Book Depreciation		6 Life in Years	7 Straight Line Depreciation		8 Adjustments	9 Accumulated Depreciation		
37	4315 Memorial Dr	1/1/2016	\$	1,114	\$	56	240	\$	56	\$	278		37
38	4315 Memorial Dr	1/1/2016		774		39	240		39		193		38
39	4315 Memorial Dr	1/1/2016		1,279		64	240		64		320		39
40	4315 Memorial Dr	1/1/2016		1,040		52	240		52		260		40
41	4315 Memorial Dr	1/1/2016		537		27	240		27		134		41
42	4315 Memorial Dr	1/1/2016		2,758		138	240		138		690		42
43	4315 Memorial Dr	1/1/2016		615		31	240		31		154		43
44	4315 Memorial Dr	1/1/2016		3,533		177	240		177		883		44
45	4315 Memorial Dr	1/1/2016		2,361		118	240		118		590		45
46	4315 Memorial Dr	1/1/2016		30,910		1,545	240		1,545		7,727		46
47	4315 Memorial Dr	1/1/2016		39,012		1,951	240		1,951		9,753		47
48	4315 Memorial Dr	1/1/2016		36,153		1,808	240		1,808		9,038		48
49	4315 Memorial Dr	1/1/2016		5,583		279	240		279		1,396		49
50	4315 Memorial Dr	1/1/2016		518		26	240		26		130		50
51	4315 Memorial Dr	1/1/2016		582		29	240		29		145		51
52	4315 Memorial Dr	1/1/2016		2,169		108	240		108		542		52
53	4315 Memorial Dr	1/1/2016		646		32	240		32		162		53
54	4315 Memorial Dr	1/1/2016		921		46	240		46		230		54
55	4315 Memorial Dr	1/1/2016		38		2	240		2		10		55
56	4315 Memorial Dr	1/1/2016		71		4	240		4		18		56
57	4315 Memorial Dr	1/1/2016		2,519		126	240		126		630		57
58	4315 Memorial Dr	1/1/2016		1,775		89	240		89		444		58
59	4315 Memorial Dr	1/1/2016		1,999		100	240		100		500		59
60	4315 Memorial Dr	1/1/2016		1,201		60	240		60		300		60
61	4315 Memorial Dr	1/1/2016		1,028		51	240		51		257		61
62	4315 Memorial Dr	1/1/2016		3,395		170	240		170		849		62
63	4315 Memorial Dr	1/1/2016		665		33	240		33		166		63
64	4315 Memorial Dr	1/1/2016		118		6	240		6		30		64
65	4315 Memorial Dr	1/1/2016		2,038		102	240		102		509		65
66	4315 Memorial Dr	1/1/2016		8,523		426	240		426		2,131		66
67	4315 Memorial Dr	1/1/2016		3,493		175	240		175		873		67
68	4315 Memorial Dr	1/1/2016		30,692		1,535	240		1,535		7,673		68
69	4315 Memorial Dr	1/1/2016		156,530		7,827	240		7,827		39,133		69
70	TOTAL (lines 4 thru 69)		\$	717,768	\$	35,888		\$	35,888	\$	179,442		70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Memorial Care Center

0003103

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 717,768	\$ 35,888		\$ 35,888	\$	\$ 179,442	1
2	4315 Memorial Dr	1/1/2016	270,878	13,544	240	13,544		67,720	2
3	4315 Memorial Dr	1/1/2016	364,374	18,219	240	18,219		91,094	3
4	4315 Memorial Dr	1/1/2016	168,418	8,421	240	8,421		42,105	4
5	4315 Memorial Dr	1/1/2016	121,967	6,098	240	6,098		30,492	5
6	4315 Memorial Dr	1/1/2016	197,702	9,885	240	9,885		49,426	6
7	4315 Memorial Dr	1/1/2016	43,250	2,162	240	2,162		10,812	7
8	4315 Memorial Dr	1/1/2016	99,539	4,977	240	4,977		24,885	8
9	4315 Memorial Dr	1/1/2016	25,501	1,275	240	1,275		6,375	9
10	4315 Memorial Dr	1/1/2016	12,721	636	240	636		3,180	10
11	4315 Memorial Dr	1/1/2016	37,891	1,895	240	1,895		9,473	11
12	4315 Memorial Dr	1/1/2016	235	12	240	12		59	12
13	4315 Memorial Dr	1/1/2016	11,890	595	240	595		2,973	13
14	4315 Memorial Dr	1/1/2016	18,237	912	240	912		4,559	14
15	4315 Memorial Dr	1/1/2016	49,706	2,485	240	2,485		12,426	15
16	4315 Memorial Dr	1/1/2016	56,174	2,809	240	2,809		14,044	16
17	4315 Memorial Dr	1/1/2016	3,948	197	240	197		987	17
18	4315 Memorial Dr	1/1/2016	7,635	382	240	382		1,909	18
19	4315 Memorial Dr	1/1/2016	5,500	275	240	275		1,375	19
20	4315 Memorial Dr	1/1/2016	511	26	240	26		128	20
21	4315 Memorial Dr	1/1/2016	377	19	240	19		94	21
22	4315 Memorial Dr	1/1/2016	5,935	297	240	297		1,484	22
23	4315 Memorial Dr	1/1/2016	8,098	405	240	405		2,024	23
24	4315 Memorial Dr	1/1/2016	2,728	136	240	136		682	24
25	4315 Memorial Dr	1/1/2016	2,797	140	240	140		699	25
26	4315 Memorial Dr	1/1/2016	6,271	314	240	314		1,568	26
27	4315 Memorial Dr	1/1/2016	2,816	141	240	141		704	27
28	4315 Memorial Dr	1/1/2016	1,647	82	240	82		412	28
29	4315 Memorial Dr	1/1/2016	2,814	141	240	141		703	29
30	4315 Memorial Dr	1/1/2016	226	11	240	11		56	30
31	4315 Memorial Dr	1/1/2016	7,428	371	240	371		1,857	31
32	4315 Memorial Dr	1/1/2016	169	8	240	8		42	32
33	4315 Memorial Dr	1/1/2016	118	6	240	6		30	33
34	TOTAL (lines 1 thru 33)		\$ 2,255,267	\$ 112,763		\$ 112,763	\$	\$ 563,817	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Memorial Care Center

0003103

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost			5 Current Book Depreciation			6 Life in Years	7 Straight Line Depreciation			8 Adjustments	9 Accumulated Depreciation			
1	Totals from Page 12B, Carried Forward		\$ 2,255,267			\$ 112,763				\$ 112,763			\$	\$ 563,817			1
2	4315 Memorial Dr	1/1/2016		4,938			247		240		247				1,235		2
3	4315 Memorial Dr	1/1/2016		1,400			70		240		70				350		3
4	4315 Memorial Dr	1/1/2016		7,521			376		240		376				1,880		4
5	4315 Memorial Dr	1/1/2016		5,644			282		240		282				1,411		5
6	4315 Memorial Dr	1/1/2016		248,933			12,447		240		12,447				62,233		6
7	4315 Memorial Dr	1/1/2016		27,074			1,354		240		1,354				6,769		7
8	4315 Memorial Dr	1/1/2016		86,987			4,349		240		4,349				21,747		8
9	4315 Memorial Dr	1/1/2016		65,940			3,297		240		3,297				16,485		9
10	4315 Memorial Dr	1/1/2016		61,896			3,095		240		3,095				15,474		10
11	4315 Memorial Dr	1/1/2016		86,232			4,312		240		4,312				21,558		11
12	4315 Memorial Dr	1/1/2016		54,854			2,743		240		2,743				13,714		12
13	4315 Memorial Dr	1/1/2016		113,783			5,689		240		5,689				28,446		13
14	4315 Memorial Dr	1/1/2016		34,378			1,719		240		1,719				8,595		14
15	4315 Memorial Dr	1/1/2016		2,037			102		240		102				509		15
16	4315 Memorial Dr	1/1/2016		40,538			2,027		240		2,027				10,134		16
17	4315 Memorial Dr	1/1/2016		31,722			1,586		240		1,586				7,931		17
18	4315 Memorial Dr	1/1/2016		19,873			994		240		994				4,968		18
19	4315 Memorial Dr	1/1/2016		6,383			319		240		319				1,596		19
20	4315 Memorial Dr	1/1/2016		97,202			4,860		240		4,860				24,301		20
21	4315 Memorial Dr	1/1/2016		112,368			5,618		240		5,618				28,092		21
22	4315 Memorial Dr	1/1/2016		84,683			4,234		240		4,234				21,171		22
23	4315 Memorial Dr	1/1/2016		91,682			4,584		240		4,584				22,921		23
24	4315 Memorial Dr	1/1/2016		175,101			8,755		240		8,755				43,775		24
25	4315 Memorial Dr	1/1/2016		33,742			1,687		240		1,687				8,436		25
26	4315 Memorial Dr	1/1/2016		24,158			1,208		240		1,208				6,040		26
27	Concrete - Oxygen MCC storage	9/1/2018		111,654			2,791		480		2,791				6,513		27
28	4315 Memorial Dr	1/1/2016		24,541			1,227		240		1,227				6,135		28
29	4315 Memorial Dr	1/1/2016		5,947			297		240		297				1,487		29
30	4315 Memorial Dr	1/1/2016		17,354			868		240		868				4,339		30
31	Finishes MCC 400 Patient Rms	9/1/2018		53,160			3,544		180		3,544				8,269		31
32	Painting MCC 400 Patient Rms	9/1/2018		6,257			1,251		60		1,251				2,920		32
33	Fire Sealant MCC Oxygen Piping	9/1/2018		10,933			2,187		60		2,187				5,102		33
34	TOTAL (lines 1 thru 33)			4,004,185			200,883				200,883				978,350		34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Memorial Care Center

0003103

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost		5 Current Book Depreciation		6 Life in Years	7 Straight Line Depreciation		8 Adjustments	9 Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward		\$ 4,004,185		\$ 200,883			\$ 200,883			\$ 978,350		1
2	Oxygen Manifold/Piping MCC 400	9/1/2018		121,683		6,084	240		6,084			14,196	2
3	Electrical MCC 400 Oxygen Adds	9/1/2018		73,088		4,060	216		4,060			9,474	3
4	Rauland 5 Nurse Call Upgrade	7/1/2018		294,190		29,419	120		29,419			73,548	4
5	Mechanical Construction	1/1/2016		181,707		9,085	240		9,085			45,427	5
6	Elevator Westinghouse Tunnel	1/1/2016		7,070		354	240		354			1,768	6
7	Mech Const Tunnel 1/2 Cost	1/1/2016		5,085		254	240		254			1,271	7
8	Sprinkler Work For C.C. Activi	1/1/2016		1,832		92	240		92			458	8
9	Installation Of Roof Top Air H	1/1/2016		6,182		309	240		309			1,546	9
10	Electrical Work Required For T	1/1/2016		3,446		172	240		172			861	10
11	Ite Siemens Transformer 45Kva	1/1/2016		628		31	240		31			157	11
12	Sq D 3P 70A 600 Vac I-Line Ckt	1/1/2016		406		20	240		20			102	12
13	Install Power Feeder From Mach	1/1/2016		3,075		154	240		154			769	13
14	Install Power Feeder From Mach	1/1/2016		3,075		154	240		154			769	14
15	Install 480V Electrical Feeder	1/1/2016		1,586		79	240		79			396	15
16	Install Emergency Power Transf	1/1/2016		1,796		90	240		90			449	16
17	Relamp Convalescent Center	1/1/2016		3,263		163	240		163			816	17
18	Install 480V Electrical Feeder	1/1/2016		3,317		166	240		166			829	18
19	Electrical Work For Replacemen	1/1/2016		1,991		100	240		100			498	19
20	Install Emergency Power Transf	1/1/2016		1,244		62	240		62			311	20
21	Reznor Model Rgb400 Air Furnac	1/1/2016		7,813		391	240		391			1,953	21
22	Install 480V Electrical Feeder	1/1/2016		5,131		257	240		257			1,283	22
23	Install 480V Electrical Feeder	1/1/2016		5,876		294	240		294			1,469	23
24	5 Ton York Air Handler & Rooft	1/1/2016		7,646		382	240		382			1,911	24
25	"Elect.Work: 1"" Conduit & 7-#	1/1/2016		3,317		166	240		166			829	25
26	Install 480V Electrical Feeder	1/1/2016		13,110		655	240		655			3,277	26
27	Asco Automatic Transfer Switch	1/1/2016		6,147		307	240		307			1,537	27
28	Electrical Work At Convalescen	1/1/2016		2,151		108	240		108			538	28
29	Electrical Work Mcc Panel Repl	1/1/2016		3,167		158	240		158			792	29
30	Electrical Work Mcc Panel Repl	1/1/2016		5,442		272	240		272			1,361	30
31	Fire Alarm Equipment Replaceme	1/1/2016		5,455		273	240		273			1,364	31
32	Mcc Heating And Cooling Unit R	1/1/2016		3,952		198	240		198			988	32
33	Plumbing Work Mcc Patient Ward	1/1/2016		8,615		431	240		431			2,154	33
34	TOTAL (lines 1 thru 33)		\$ 4,796,672		\$ 255,622			\$ 255,622			\$ 1,151,450		34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Memorial Care Center

0003103

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost		5 Current Book Depreciation		6 Life in Years	7 Straight Line Depreciation		8 Adjustments	9 Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward		\$ 4,796,672		\$ 255,622			\$ 255,622			\$ 1,151,450		1
2	Window Replacement Mcc	1/1/2016		6,487		324	240		324			1,622	2
3	Plumbing Work Mcc Renovations	1/1/2016		117		6	240		6			29	3
4	Plumbing Work Mcc Renovations	1/1/2016		281		14	240		14			70	4
5	Beauty Shop Utility Room Mcc	1/1/2016		2,374		119	240		119			593	5
6	Rooftop Air Handler In Hallway	1/1/2016		4,875		244	240		244			1,219	6
7	Construction Work Mcc Walls An	1/1/2016		11,458		573	240		573			2,864	7
8	Electrical Work Mcc Idph Requi	1/1/2016		9,766		488	240		488			2,442	8
9	Painting Mcc Idph Survey	1/1/2016		586		29	240		29			147	9
10	Hvac Work Mcc Fire Dampers	1/1/2016		6,530		327	240		327			1,633	10
11	Air Handler Replacement-Carrie	1/1/2016		4,875		244	240		244			1,219	11
12	Heating & Cooling Units Frigid	1/1/2016		16,143		807	240		807			4,036	12
13	Professiona Design Services-Mc	1/1/2016		12,552		628	240		628			3,138	13
14	Meecho Shades Cornice Board	1/1/2016		5,691		285	240		285			1,423	14
15	Electrical Work - Convalescent	1/1/2016		1,317		66	240		66			329	15
16	Gas Furnaces Ac Units Evapor	1/1/2016		8,030		401	240		401			2,007	16
17	Construction Of Cc Walking Tr	1/1/2016		9,769		977	120		977			4,884	17
18	Rails For Ramp & Stairs At Cc	1/1/2016		1,174		117	120		117			587	18
19	Asphalt The Convalescent Cente	1/1/2016		55,987		5,599	120		5,599			27,993	19
20	Concrete Work Required For The	1/1/2016		47,614		4,761	120		4,761			23,807	20
21	Electrical Work Required For C	1/1/2016		10,496		1,050	120		1,050			5,248	21
22	Sidewalk East Side Mcc	1/1/2016		9,961		996	120		996			4,980	22
23	Landscaping - MCC Bldg	9/1/2018		1,717		86	240		86			200	23
24	Fencing - MCC 400 Oxygen Adds	9/1/2018		9,784		1,957	60		1,957			4,566	24
25	Courtyard Drainage & Plants	9/1/2016		14,075		1,408	120		1,408			6,099	25
26													26
27													27
28													28
29													29
30													30
31													31
32													32
33													33
34	TOTAL (lines 1 thru 33)		\$ 5,048,329		\$ 277,127			\$ 277,127			\$ 1,252,585		34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 5,048,329	\$ 277,127	\$ 277,127	\$		\$ 1,252,585	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 5,048,329	\$ 277,127	\$ 277,127	\$		\$ 1,252,585	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Ford Bus	2000	1/1/2016	\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	10,184,392
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	554,253
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	554,253
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,505,170

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86	NA	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☒ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 109,276
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	\$ 658,927		\$	\$ 3,265		\$ 662,192	1
2	Licensed Speech and Language Development Therapist	10a	hrs	216,510			951		217,461	2
3	Licensed Recreational Therapist	11	hrs	78,202			5,849		84,051	3
4	Licensed Physical Therapist	10a	hrs	845,818			5,767		851,585	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	43	# of prescrpts	263,200			402,547		665,747	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 2,062,657		\$	\$ 418,379		\$ 2,481,036	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 106,847	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 64,541,172)	22,677,072		3
4	Supply Inventory (priced at)	3,074,848		4
5	Short-Term Investments			5
6	Prepaid Insurance	857,193		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Receivables	844,674		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 27,560,634	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,233,977		12
13	Land	1,930,000		13
14	Buildings, at Historical Cost	53,069,837		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	51,831,541		16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(52,339,758)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	6,017,965		22
23	Other(specify): Land Imp. + Other Assets	7,233,309		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 68,976,871	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 96,537,505	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,620,594	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,831,511		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	1,020,607		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payroll w/h	2,985,968		36
37	Accrued PTO, Benefits and Other	56,364,538		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 66,823,218	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Self Ins. Profess Liability	6,908,424		43
44	Accue Eviro Liab, LT Accural, WC	5,187,566		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,095,990	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 78,919,208	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 17,618,297	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 96,537,505	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 75,159,441	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 75,159,441	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	10,210,650	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Hospital	(67,751,794)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (57,541,144)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 17,618,297	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Memorial Care Center

0003103

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,802,081	1
2	Discounts and Allowances for all Levels	(25,349,432)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ (19,547,351)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	17,834,196	6
7	Oxygen	1,448,290	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 19,282,486	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	6,218,013	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,855,202	19
20	Radiology and X-Ray	246,464	20
21	Other Medical Services	155,836	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 10,475,515	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,210,650	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services		31
32	Health Care		32
33	General Administration		33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	40
41	Income before Income Taxes (line 30 minus line 40)**	10,210,650	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 10,210,650	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ (6,404)	44
45	Private Pay - Net Inpatient Revenue	(578,294)	45
46	Medicare - Net Inpatient Revenue	(11,725,524)	46
47	Other-(specify) <u>Medicare Advantage</u>	(7,237,129)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ (19,547,351)	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing	1,714	1,802	69,204	38.40	2
3	Registered Nurses	41,638	43,510	1,968,103	45.23	3
4	Licensed Practical Nurses	8,393	13,463	402,219	29.88	4
5	CNAs & Orderlies	59,193	66,511	1,251,974	18.82	5
6	CNA Trainees					6
7	Licensed Therapist	39,343	49,183	1,627,674	33.09	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	961	3,181	78,202	24.58	10
11	Social Service Workers	3,014	3,459	88,056	25.46	11
12	Dietician	1,728	14,768	249,815	16.92	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	392	3,604	82,358	22.85	17
18	Housekeepers	7,719	9,250	135,770	14.68	18
19	Laundry					19
20	Administrator	1,888	6,290	185,237	29.45	20
21	Assistant Administrator					21
22	Other Administrative	4,784	13,486	316,137	23.44	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	4,828	5,024	201,833	40.17	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	1,184	9,877	393,393	39.83	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	176,779	243,408	\$ 7,049,975 *	\$ 28.96	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,904	\$ 165,027	L. 10; C. 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	921	20,953	L. 10; C. 3	52
53	TOTAL (lines 50 - 52)	3,825	\$ 185,980		53

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

No

(2) Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 12,534

Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 103,224

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 4,502

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 208,976

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17) Has an audit been performed by an independent certified public accounting firm?

Firm Name:

E&Y - as part of year end for Memorial Hospital and BJC Health System

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

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