

		FOR BHF USE						

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: <u>0003103</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Memorial Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2025</u> to <u>12/31/2025</u> 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.																																																	
Address: <u>4315 Memorial Drive</u> <u>Belleville</u> <u>62226</u> Number City Zip Code																																																			
County: <u>Saint Clair</u>																																																			
Telephone Number: <u>(618) 619-5000</u> Fax # <u>(618) 641-9215</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: _____		Officer or Administrator of Provider (Signed) _____ (Date) _____																																																	
Type of Ownership:		(Type or Print Name) _____																																																	
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Trust</td><td>☐</td><td></td></tr><tr><td>☐</td><td></td><td>☐</td><td>Other _____</td><td>☐</td><td></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	☐		☐	Corporation	☐	Other _____	☐		☐	"Sub-S" Corp.	☐		☐		☐	Limited Liability Co.	☐		☐		☐	Trust	☐		☐		☐	Other _____	☐		(Title) _____	
☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL																																														
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☐		☐	Corporation	☐	Other _____																																														
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☐		☐	Limited Liability Co.	☐																																															
☐		☐	Trust	☐																																															
☐		☐	Other _____	☐																																															
IRS Exemption Code <u>501(c)(3)</u>		Paid Preparer (Signed) _____ (Date) _____																																																	
		(Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Signing Director</u>																																																	
		(Firm Name & Address) <u>CliftonLarsonAllen LLP</u> <u>600 Washington Ave. Ste. 1800, St. Louis, MO 63101</u>																																																	
		(Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u>																																																	
In the event there are further questions about this report, please contact		MAIL TO: BUREAU OF HEALTH FINANCE																																																	
Name: <u>Kevin Wellen, CPA</u>		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES																																																	
Telephone Number: <u>(314) 925-4300</u>		2200 Churchill Rd.																																																	
Email Address: _____		Springfield, IL 62702-3406 Phone # (217) 782-1630																																																	

STATE OF ILLINOIS

Page 2

Facility Name & ID Number

Memorial Care Center

#

0003103

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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	82	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	82	TOTALS	82	29,930	7

B. Census-For the entire report period.

1

2

3

4

5

6

7

8

9

	Level of Care	Medicaid Fee for Service	Medicaid MLTSS	MMAI Medicaid Primary	Medicare Primary	Private Pay	Medicare Part A Only	Other	Total	
8	SNF					383	8,434	14,246	23,063	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS					383	8,434	14,246	23,063	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

77.06%

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

X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

X

I. On what date did you start providing long term care at this location?

Date started

3/3/1964

J. Was the facility purchased or leased after January 1, 1978?

YES

Date

NO

X

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter certified beds.

number of certified beds

82

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

12/31/2025

Fiscal Year:

12/31/2025

* All facilities other than governmental must report on the accrual basis.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
1	Dietary	81,385		417,734	499,119		499,119		499,119		1
2	Food Purchase		417,734		417,734		417,734		417,734		2
3	Housekeeping	262,098	60,702	1,484	324,284		324,284		324,284		3
4	Laundry			77,242	77,242		77,242		77,242		4
5	Heat and Other Utilities			159,692	159,692		159,692		159,692		5
6	Maintenance		2,133	134,055	136,188		136,188		136,188		6
7	Other (specify):*										7
8	TOTAL General Services	343,483	480,569	790,207	1,614,259		1,614,259		1,614,259		8
	B. Health Care and Programs										
9	Medical Director					7,800	7,800		7,800		9
10	Nursing and Medical Records	5,590,318	312,944	709,014	6,612,276		6,612,276		6,612,276		10
10a	Therapy										10a
11	Activities	131,346	5,829	3,670	140,845		140,845		140,845		11
12	Social Services	168,567	126		168,693		168,693		168,693		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,890,231	318,899	712,684	6,921,814	7,800	6,929,614		6,929,614		16
	C. General Administration										
17	Administrative	140,583			140,583		140,583		140,583		17
18	Directors Fees										18
19	Professional Services			1,346,045	1,346,045	(8,300)	1,337,745		1,337,745		19
20	Dues, Fees, Subscriptions & Promotions			72,518	72,518	500	73,018	(48,709)	24,309		20
21	Clerical & General Office Expenses	280,981	80,001	14,166	375,148		375,148	(11,533)	363,615		21
22	Employee Benefits & Payroll Taxes			1,019,320	1,019,320		1,019,320		1,019,320		22
23	Inservice Training & Education			4,735	4,735		4,735		4,735		23
24	Travel and Seminar			7,553	7,553		7,553		7,553		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			267,917	267,917		267,917		267,917		26
27	Other (specify):*										27
28	TOTAL General Administration	421,564	80,001	2,732,254	3,233,819	(7,800)	3,226,019	(60,242)	3,165,777		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,655,278	879,469	4,235,145	11,769,892		11,769,892	(60,242)	11,709,650		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
		1	2	3	4	5	6	7	8		
30	D. Ownership										30
	Depreciation			194,369	194,369		194,369		194,369		
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			88,446	88,446		88,446		88,446		35
36	Other (specify):*										36
37	TOTAL Ownership			282,815	282,815		282,815		282,815		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	1,524,744	880,889	129,139	2,534,772		2,534,772		2,534,772		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			15,373	15,373		15,373		15,373		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers	1,524,744	880,889	144,512	2,550,145		2,550,145		2,550,145		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,180,022	1,760,358	4,662,472	14,602,852		14,602,852	(60,242)	14,542,610		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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(48,709)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising	(11,533)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,242)		\$	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	2	
		Amount	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))	\$ (60,242)		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	2	3	4	
		Yes	No	Amount	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: 1/1/2025

Ending: 12/31/2025

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Political Action Committee Payments	\$	20	1
2	Other Expenses Related to Lobbying Activities		20	2
3				3
4	Misc. Income	(10,485)	21	4
5				5
6	Lost Personal Property	(1,048)	21	6
7				7
8				8
9				9
10				10
11				11
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41				41
42				42
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44				44
45				45
46				46
47				47
48				48
49	Total	(11,533)		49

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
See BOD at "Ownership-1"		Alton Memorial Rehab & Therapy	Alton, IL			

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 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary Services	\$ 369,337	BJC - Memorial Hospital	100.00%	\$ 369,337		1
2	V	2	Food	368,383	BJC - Memorial Hospital	100.00%	368,383		2
3	V	3	Ancillary Services	51	BJC Healthcare		51		3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 737,771			\$ 737,771	\$ *	14

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

Ownership Listing-1

ID# 0003103

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Place of Residence

Operator/Licensee

Building Co.

**Management
Co. /Home Office**

-Names of trust beneficiaries must be listed.			Place of Residence	Ownership
First Name	M.I.	Last Name	City	State
				Percentage

1	Deborah		Graves					1
2	Jeff		Dossett					2
3	Shelley		Perulfi					3
4	Susan		Koesterer					4
5	Chuck		Robb					5
6	Kevin		Journagan					6
7	Chris		Eckert					7
8	Geri		Boyer					8
9	Rachel		Jackson					9
10	Keith		Cook					10
11	Robert		Dyer					11
12	Randy		Ganim					12
13	Edward		Hoering					13
14	Becky		Olroyd					14
15	Hans		Moosa					15
16	Staci		Oliver					16
17	Beatriz (Bea)		Ramos-Pardo					17
18	Kurt		Schroeder					18
19	Ronald		Stephens					19
20	Valerie		Thaxton					20
21								21
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75								75

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	N/A							1
2								2
3								3
4								4
5								5
6								6
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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	N/A								\$		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.

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
Street Address
City / State / Zip Code
Phone Number
Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	N/A					\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	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	N/A						\$	\$			\$		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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 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 2025 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	
Assessed Value from Real Estate Tax Bill: 2024 8					
Real Estate Tax Bill for Calendar Year: 2020 9					
2021 10					
2022 11					
2023 12					
2024 13					
		FOR BHF USE ONLY			
		14	FROM R. E. TAX STATEMENT FOR 2024 \$	14	
		15	PLUS APPEAL COST FROM LINE 5 \$	15	
		16	LESS REFUND FROM LINE 6 \$	16	
		17	AMOUNT TO USE FOR RATE CALCULATION \$	17	

- 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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Memorial Care Center

COUNTY

Saint Clair

FACILITY IDPH LICENSE NUMBER

0003103

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE

FAX #:

()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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.

X. BUILDING AND GENERAL INFORMATION:

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.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

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 ground (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. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

No

J. 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.

K. 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:

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

XL 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	82			2016	\$ 2,426,091	\$ 118,585		\$ 118,585	\$	1,690,513	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2016 Land Improvements			2016	120,220					120,220	9
10	2016 Fixed Equipment Additions			2016	244,676	12,202	Various	12,202		174,072	10
11	Finishes MCC 400 Patient Rms			2018	30,943	2,063		2,063		21,422	11
12	Painting MCC 400 Patient Rms			2018	5,544					5,544	12
13	Fire Sealant MCC Oxygen Piping			2018	9,687					9,687	13
14	Landscaping - MCC Bldg			2018	934	47		47		509	14
15	Fencing - MCC 400 Oxygen Adds			2018	8,669					8,669	15
16	Rauland 5 Nurse Call Upgrade			2018	196,386	19,638		19,638		190,486	16
17	Oxygen Manifold/Piping MCC 400			2018	66,204	3,310		3,310		36,064	17
18	Electrical MCC 400 Oxygen Adds			2018	40,691	2,261		2,261		24,227	18
19	Door Access MCC Doors			2021	6,910	461		461		2,724	19
20	Multi Class Reader Electrical			2021	4,341	241		241		1,436	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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

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	\$ 253,041	\$ 35,292	\$ 35,292	\$		\$ 191,740	71
72	Current Year Purchases	11,300	269	269			269	72
73	Fully Depreciated Assets	534,155					534,155	73
74								74
75	TOTALS	\$ 798,496	\$ 35,561	\$ 35,561	\$		\$ 726,164	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets				1 Reference	2 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)			\$ 4,047,526	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 194,369	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 194,369	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 3,011,737	85

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		\$	\$	\$
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: N/A
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: \$ 88,446
- Description: Medical equipment, copier rental
- (Attach a schedule detailing the breakdown of movable equipment)

	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

10. Effective dates of current rental agreement:
- Beginning
- Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending
- Annual Rent
12. /2026 \$
13. /2027 \$
14. /2028 \$

* 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

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)	\$					

- (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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (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.)

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5		6 Supplies (Actual or Allocated)		7 Total Units (Column 2 + 4)		8 Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost			Units	Cost									
1	Licensed Occupational Therapist	V39-1 & V39-2	hrs	\$ 554,838					\$ 888			\$ 555,726			1		
2	Licensed Speech and Language Development Therapist	V39-1 & V39-2	hrs	208,682											208,682	2	
3	Licensed Recreational Therapist		hrs													3	
4	Licensed Physical Therapist	V39-1 & V39-2	hrs	761,224						5,983					767,207	4	
5	Physician Care		visits													5	
6	Dental Care		visits													6	
7	Work Related Program		hrs													7	
8	Habilitation		hrs													8	
9	Pharmacy	V39-2	# of prescripts							873,612					873,612	9	
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10	
11	Academic Education		hrs													11	
12	Other (specify): <u>X-ray & Lab</u>	V39-3							129,139	406					129,545	12	
13	Other (specify): _____															13	
14	TOTAL			\$ 1,524,744				\$ 129,139	\$ 880,889			\$ 2,534,772				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	\$ 22,034	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 288,299)	2,153,440		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,474		6
7	Other Prepaid Expenses	3,619		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,189,567	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	87,734		13
14	Buildings, at Historical Cost	2,479,174		14
15	Leasehold Improvements, at Historical Cost	129,823		15
16	Equipment, at Historical Cost	1,350,795		16
17	Accumulated Depreciation (book methods)	(3,011,737)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,035,789	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,225,356	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 223,353	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
	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			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	(7,338,119)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (7,114,766)	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (7,114,766)	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,340,122	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,225,356	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,042,081	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,042,081	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,552,885	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) Additional Paid In Capital BJC	1,745,156	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 3,298,041	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)	\$ 10,340,122	24 *

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,447,471	1
2	Discounts and Allowances for all Levels	(7,572,416)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,875,055	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,632,804	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,632,804	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	1,177,117	17
18	Sale of Supplies to Non-Patients	2,460,276	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,637,393	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	Other Revenue	10,485	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,485	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,155,737	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,614,259	31
32	Health Care	6,921,814	32
33	General Administration	3,233,819	33
B. Capital Expense			
34	Ownership	282,815	34
C. Ancillary Expense			
35	Special Cost Centers	2,534,772	35
36	Provider Participation Fee	15,373	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,602,852	40
41	Income before Income Taxes (line 30 minus line 40)**	1,552,885	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,552,885	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 2,864.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	-109,132.00	48
49	Medicare Part A	1,792,182.00	49
50	Other-(specify) Managed Care	3,189,141.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,875,055	56

		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	1,616	1,616	\$ 92,189	\$ 57.05	1
2	Assistant Director of Nursing	1,888	1,888	96,783	51.26	2
3	Registered Nurses	37,712	37,712	2,041,869	54.14	3
4	Licensed Practical Nurses	28,456	28,456	1,606,631	56.46	4
5	CNAs & Orderlies	57,341	57,341	1,752,846	30.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	31,131	31,131	1,524,744	48.98	8
9	Activity Director	1,944	1,944	88,790	45.67	9
10	Activity Assistants	1,815	1,815	42,556	23.45	10
11	Social Service Workers	5,385	5,385	168,567	31.30	11
12	Dietician	1,901	1,901	81,385	42.81	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	11,078	11,078	262,098	23.66	18
19	Laundry					19
20	Administrator	1,912	1,912	140,583	73.53	20
21	Assistant Administrator					21
22	Other Administrative	5,772	5,772	249,451	43.22	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,575	1,575	31,530	20.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,526	189,526	\$ 8,180,022 *	\$ 43.16	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	Monthly	7,800	V09-3	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)		\$ 7,800		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,114	\$ 434,727	V10-3	50
51	Licensed Practical Nurses	2,640	176,905	V10-3	51
52	Certified Nurse Assistants/Aides	772	27,744	V10-3	52
53	TOTAL (lines 50 - 52)	8,526	\$ 639,376		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Keri Bryer	Administrator	0	\$ 140,583	Workers' Compensation Insurance	\$	338,778	IDPH License Fee	\$ 500
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	35,879
				FICA Taxes		257,023	Health Care Worker Background Check	
				Employee Health Insurance		281,080	(Indicate # of checks performed)	
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	
				Medicare Taxes		60,110	Public Relations	12,717
				TSA Pension		56,143	Subscriptions/Dues	17,467
				Life and Disability		22,694	Licenses & Permits	6,455
				Other Incentives		3,492		
							Less: Public Relations Expense	(48,709)
							PAC and Lobbying payments	()
							All non-allowable advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,			TOTAL (agree to Sch. V,	
(List each licensed administrator separately.)				line 22, col.8)			line 20, col. 8)	
\$ 140,583				\$ 1,019,320			\$ 24,309	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
				to Owners or Employees				
Description			Amount	Description	Line #	Amount	Description	Amount
			\$	N/A		\$	Out-of-State Travel	\$
							In-State Travel	538
							Seminar Expense	7,015
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL			(agree to Sch. V,	
(Attach a copy of any management service agreement)				\$			line 24, col. 8)	
\$ 1,346,045							TOTAL	
							(agree to Sch. V,	
							line 24, col. 8)	
							\$ 7,553	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number

Memorial Care Center

STATE OF ILLINOIS

#0003103

Report Period Beginning:1/1/2025

Ending:12/31/2025

Page 22

XX. GENERAL INFORMATION:

(1)

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

No

(2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below
Use the drop down list to identify the association.

Association Name

Amount

Total

(3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1

Total

(4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

Total

(5)

Indicate the total amount of both disposable and non-disposable incontinent expens
and the location of this expense on Sch. V.

\$67,040

Line10

(6)

Have all costs reported on this form been determined using accounting procedure
consistent with prior reports?

Yes

If NO, attach a complete explanation.

(7)

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

\$15,373

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

(8)

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.

(9)

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

(10)

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.

(11)

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

\$

Yes

Has any meal income been offset against
related costs?

Indicate the amount.

\$

(12)

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.

\$N/A

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

0

d. Have vehicle usage logs been maintained?

N/A

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?

Yes

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.

\$N/A

(13)

Has an audit been performed by an independent certified public accounting firm

Firm Name:

Yes

(14)

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

Yes

(15)

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.

Yes

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