		FOR BHF USE			

LL1

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.

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

I. IDPH License ID Number: 0003103

Facility Name: Memorial Care Center

Address: 4315 Memorial Drive (Number) Belleville (City) 62226 (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	PROPRIETARY	GOVERNMENTAL
[X] VOLUNTARY,NON-PROFIT	[ ] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code	[ ] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment Medicaid Recipient	3 Private Pay	4 Other	5 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 [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 03/ 03 / 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 number of beds certified 82 and days of care provided ______

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: 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
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
45	**GRAND TOTAL COST (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.**

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

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	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (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

STATE OF ILLINOIS

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
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
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

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 A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY 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

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY 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

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

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: 1/1/2020 Ending: 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 X NO

Name of Related Organization: Memorial Hospital Belleville
Street Address: 4500 Memoiral Drive
City / State / Zip Code: Belleville, IL 62226
Phone Number: ( )
Fax Number: ( )

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
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	Requistions	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

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

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.)**

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

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 2019 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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Memorial Care Center COUNTY St 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 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.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 ______ 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 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

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 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 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 Uprgrade	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.

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

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	$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

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)	$ 10,184,392	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 554,253	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 554,253	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)	$ 2,505,170	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	NA	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	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.

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

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: *

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [X] 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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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
   - [X] 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)	$			

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	

(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.

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

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 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 Operating	2 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.)

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

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.

	I. Revenue	1 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

	II. Expenses	2 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) Medicare Advantage	(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.

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

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

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,641
Unemployment Compensation Insurance	
FICA Taxes	462,510
Employee Health Insurance	690,611
Employee Meals	4,502
Illinois Municipal Retirement Fund (IMRF)*	
Dental	24,764
Pension	296,211
Life, Long Term, Short Term Ins.	30,013
Other Benefits	66,199
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,653,451

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Professional Dues	1,520
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,520

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Nursing travel/mileage for meeting	0
In-State Travel	
Seminar Expense	
Nursing seminars	1,799
Therapist seminars	228
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,027

**See instructions.

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

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.