

Facility Name & ID Number Memorial Care Center

003103 Report Period Beginning: 1/01/2018 Ending: 12/31/2018

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 82

	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 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	69		24,742	24,811	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69		24,742	24,811	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.90%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 82 and days of care provided 15,596

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Memorial Care Center # 003103 Report Period Beginning: 1/01/2018 Ending: 12/31/2018

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
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	746,574		35,627	782,201	(38,654)	743,547		743,547		1
2	Food Purchase		3,027		3,027		3,027		3,027		2
3	Housekeeping	144,879	32,915	117,541	295,335	(77,511)	217,824		217,824		3
4	Laundry					22,668	22,668	35,856	58,524		4
5	Heat and Other Utilities			101,408	101,408	4,958	106,366		106,366		5
6	Maintenance	78,360	2,350	74,918	155,628	(90,780)	64,848		64,848		6
7	Other (specify):*										7
8	TOTAL General Services	969,813	38,292	329,494	1,337,599	(179,319)	1,158,280	35,856	1,194,136		8
	B. Health Care and Programs										
9	Medical Director					6,396	6,396		6,396		9
10	Nursing and Medical Records	4,119,118	353,164	1,509,172	5,981,454	(1,151,200)	4,830,254	797,033	5,627,287		10
10a	Therapy	1,999,907	12,801	531,477	2,544,185	(439,709)	2,104,476	3,809,994	5,914,470		10a
11	Activities	61,741			61,741	(20,938)	40,803		40,803		11
12	Social Services	78,823		13,103	91,926	(13,103)	78,823		78,823		12
13	CNA Training	32,130			32,130		32,130		32,130		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	6,291,719	365,965	2,053,752	8,711,436	(1,618,554)	7,092,882	4,607,027	11,699,909		16
	C. General Administration										
17	Administrative										17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	4,182	20,883	285,622	310,687	(231,584)	79,103	2,521,584	2,600,687		21
22	Employee Benefits & Payroll Taxes					1,564,431	1,564,431	18,059	1,582,490		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice					56,334	56,334		56,334		26
27	Other (specify):*										27
28	TOTAL General Administration	4,182	20,883	285,622	310,687	1,389,181	1,699,868	2,539,643	4,239,511		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,265,714	425,140	2,668,868	10,359,722	(408,692)	9,951,030	7,182,526	17,133,556		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.

Facility Name & ID Number Memorial Care Center

#003103

Report Period Beginning:

1/01/2018

Ending:

12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation					361,029	361,029	(352,101)	8,928			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			134,808	134,808		134,808	(134,807)	1			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					378	378		378			34
35	Rent-Equipment & Vehicles					66,338	66,338		66,338			35
36	Other (specify):*											36
37	TOTAL Ownership			134,808	134,808	427,745	562,553	(486,908)	75,645			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	132,106	1,281	120,035	253,422	(5,363)	248,059	360,778	608,837			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	28,174			28,174		28,174		28,174			41
42	Provider Participation Fee											42
43	Other (specify):* Pharmacy	333,623	524,326	13,689	871,638	(13,690)	857,948	372,227	1,230,175			43
44	TOTAL Special Cost Centers	493,903	525,607	133,724	1,153,234	(19,053)	1,134,181	733,005	1,867,186			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,759,617	950,747	2,937,400	11,647,764		11,647,764	7,428,623	19,076,387			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				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	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		37

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

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

		1	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# 003103

Report Period Beginning: 1/01/2018

Ending: 12/31/2018

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
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24			24
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26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Memorial Care Center# 003103

Report Period Beginning:

1/01/2018

Ending:

12/31/2018

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

	Operating Expenses	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)	
	A. General Services													
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	35,856	0	0	0	0	0	0	0	0	0	35,856	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	35,856	0	0	0	0	0	0	0	0	0	35,856	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	797,033	0	0	0	0	0	0	0	0	0	797,033	10
10a	Therapy	0	3,809,994	0	0	0	0	0	0	0	0	0	3,809,994	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	4,607,027	0	0	0	0	0	0	0	0	0	4,607,027	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	2,521,584	0	0	0	0	0	0	0	0	0	2,521,584	21
22	Employee Benefits & Payroll Taxes	0	18,059	0	0	0	0	0	0	0	0	0	18,059	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	2,539,643	0	0	0	0	0	0	0	0	0	2,539,643	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	7,182,526	0	0	0	0	0	0	0	0	0	7,182,526	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Memorial Care Center

003103

Report Period Beginning:

1/01/2018

Ending:

12/31/2018

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	(352,101)	0	0	0	0	0	0	0	0	0	(352,101)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(134,807)	0	0	0	0	0	0	0	0	0	(134,807)	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	(486,908)	0	0	0	0	0	0	0	0	0	(486,908)	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	360,778	0	0	0	0	0	0	0	0	0	360,778	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	372,227	0	0	0	0	0	0	0	0	0	372,227	43
44	TOTAL Special Cost Centers	0	733,005	0	0	0	0	0	0	0	0	0	733,005	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	7,428,623	0	0	0	0	0	0	0	0	0	7,428,623	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	39 Radiology, CAT, Lab, RT, Cardiac	\$ 248,980	Memorial Hospital		\$ 609,758	\$ 360,778	1
2	V	10a Therapies	1,861,524			5,671,518	3,809,994	2
3	V	43 Pharmacy	857,948			1,230,175	372,227	3
4	V	32 Allowable Interest Expense	134,808			1	(134,807)	4
5	V	30 Depreciation	361,029			8,928	(352,101)	5
6	V	21 A&G Overhead allocations from hospit	1			2,521,585	2,521,584	6
7	V	4 Laundryoverhead allocation from hosp	1			35,857	35,856	7
8	V	22 Employee meals from hosp.cafeteria	1			18,060	18,059	8
9	V	10 Nurs Adm & Med Rec overhead alloc f	1			797,034	797,033	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 3,464,293			\$ 10,892,916	\$ * 7,428,623	14

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

Facility Name & ID Number

Memorial Care Center

003103

Report Period Beginning:

1/01/2018

Ending:

12/31/2018

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	Adriena Beatty	BOD						1
2	Geri Boyer	BOD						2
3	Douglas Dothager MD	BOD						3
4	Robert Dyer	BOD						4
5	Scott Givens	BOD						5
6	Edward Hoering	BOD						6
7	Rachel Jackson	BOD						7
8	Matthew Klosterman	BOD						8
9	Claire Leopold	BOD						9
10	Tracy McCollum	BOD						10
11	Robert C. Mueller	BOD						11
12	Beatriz Ramos-Pardo MD	BOD						12
13	Roland Thouvenot	BOD						13
14	Otto Roberts	BOD						14
15	Mark Turner	BOD						15
16	Adele Theobald	BOD						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

Facility Name & ID Number Memorial Care Center # 003103 Report Period Beginning: 1/01/2018 Ending: 12/31/2018

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									\$		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

003103

Report Period Beginning:

1/01/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Memorial Hospital
 Street Address 4500 Memorial Drive
 City / State / Zip Code Belleville, IL 62226
 Phone Number (618-233-7750
 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	39	Radiology	revenue	55,992,414	2	\$ 6,923,770	\$ 2,350,396	299,026	\$ 36,976	1
2	39	CAT Scan	revenue	91,798,012	2	2,496,701	609,296	8,331	227	2
3	39	Laboratory	revenue	151,194,482	2	10,763,159	4,231,475	3,871,732	275,619	3
4	39	Respiratory Therapy	revenue	40,918,605	2	4,181,061	1,916,240	2,748,515	280,843	4
5	39	Cardiology	revenue	56,875,535	2	2,967,764	1,257,577	210,748	10,997	5
6	39	MRI	revenue	18,423,526	2	1,349,631	290,197	69,568	5,096	6
7	10a	Physical Therapy	revenue	43,258,514	2	8,424,641	4,569,209	15,744,081	3,066,176	7
8	10a	Occupational Therapy	revenue	13,297,944	2	2,925,655	1,284,521	9,067,722	1,994,972	8
9	10a	Speech Therapy	revenue	3,477,767	2	1,267,508	648,028	1,674,722	610,370	9
10	43	Drugs	revenue	104,156,754	2	13,054,849	3,136,732	9,814,820	1,230,175	10
11	32	Interest Expense	actual	0	2					11
12	30	Depreciation	actual	15,510,984	2	372,133		372,133	8,928	12
13	21	Communications	phones	1,763	2	300,065	171,173	51	8,680	13
14	21	Data Processing	resources	9,154	2	11,121,508	33,897	376	456,815	14
15	21	Purchasing	requisitions	2,299,827	2	205,058	13,160	48,475	4,322	15
16	21	Admitting	pt days	75,541	2	1,176,347	876,943	24,811	386,364	16
17	21	Patient Accounts	gross chgs	992,699,582	2	2,697,694	1,395,102	6,960,068	18,914	17
18	21	Admin & General	accumulated cost	183,994,839	2	33,764,047	6,559,063	8,972,432	1,646,490	18
19	4	Laundry	pounds	1,064,908	2	297,087	0	128,531	35,857	19
20	22	Cafeteria-empl meals	empl meals	99,877	2	250,590	169,026	7,198	18,060	20
21	10	Nursing Admin	time spent	882,011	2	5,830,703	2,699,856	53,352	352,694	21
22	10	Medical Records	time spent	24,190	2	2,329,560	571,940	4,614	444,340	22
23					2					23
24										24
25	TOTALS					\$ 112,699,531	\$ 32,783,831		\$ 10,892,915	25

Facility Name & ID Number

Memorial Care Center

003103

Report Period Beginning:

1/01/2018

Ending:

12/31/2018

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		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 Eliminated		All Interest Expense Eliminated			\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	14							
15	TOTALS (line 9+line14)					\$	\$			\$	15							

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

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

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

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

B. Real Estate Taxes

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 2017 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 2018 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:	2013	8	
	2014	9	
	2015	10	
	2016	11	
	2017	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017 \$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Memorial Care Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 003103

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE 618-233-7750 FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

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

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 a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.**

Facility Name & ID Number Memorial Care Center

003103

Report Period Beginning:

1/01/2018 Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,001 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).

Blank lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Use, Square Feet, Year Acquired 1964, Cost \$ 87,734, 1. Row 2: 2, 2. Row 3: 3 TOTALS, \$ 87,734, 3.

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	82		1964	1964	\$ 882,395	\$	23	\$	\$	\$ 882,395	4
5			1969		83,787		18			83,787	5
6											6
7											7
8											8
	Improvement Type**										
9		Electrical Upgrade		1996	20,716		20			20,716	9
10		Walking Track		1998	7,690		15			7,690	10
11		7 1/2 ton AC unit		1998	14,326		15			14,326	11
12		Air furnace		1998	15,226		15			15,226	12
13		5 ton air handler		1998	14,900		15			14,900	13
14		Electrical work-boiler room, AC unit,relamp, auto tr switch		1998	91,162	4,557	20	4,557		93,436	14
15		Air handling unit		1994	12,048		15			12,048	15
16		Repair parking lot		1994	80,182		15			80,182	16
17		Activity Therapy renovation		1993	3,571		5			3,571	17
18		Land improvements		1968	2,170		40			2,170	18
19		Electrical work		1999	2,566	128	20	128		2,500	19
20		New door physical therapy		2000	3,735		15			3,735	20
21		Porch columns		2000	5,965		15			5,965	21
22		Repair walls		2001	2,080		15			2,080	22
23		Electrical work		2001	4,191	210	20	210		3,669	23
24		Electrical work		2001	16,778	838	20	838		14,677	24
25		Window replacement		2002	113,345		15			113,345	25
26		Storage addition		2002	253,195		15			253,195	26
27		Storage addition		2002	4,227		5			4,227	27
28		Storage addition		2002	1,259		1			1,259	28
29		Fire Alarm/Nurse Call Replacement		2002	4,473		15			4,473	29
30		Fire Alarm/Nurse Call Replacement		2002	1,001		5			1,001	30
31		Fire Alarm/Nurse Call Replacement		2002	48,125		10			48,125	31
32		Fire Alarm/Nurse Call Replacement		2002	490		15			490	32
33		Fire Alarm/Nurse Call Replacement		2002	61,775	3,091	20	3,091		50,974	33
34		Patient Wardrobe Units		2002	67,813		15			67,813	34
35		Patient Wardrobe Units		2002	5,824		10			5,824	35
36		Heating and Cooling Unit		2002	7,702		15			7,702	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

003103

Report Period Beginning:

1/01/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	8" Faucets	2002	\$ 5,318	\$ 266	20	\$ 266	\$	\$ 4,389	37
38	Window Replacement	2003	75	7	15	7		82	38
39	Storage Addition	2003	138	9	15	9		141	39
40	Fire Alarm/Nurse Call Replacement	2003	659		10			659	40
41	Window Replacement	2003	16,451	546	15	546		16,451	41
42	Patient Wardrobe Units	2003	16,789	840	20	840		13,013	42
43	Fire Alarm/Nurse Call Replacement	2003	19,745	988	20	988		15,303	43
44	Utility Storage Room Plumbing Work	2004	776	38	20	38		558	44
45	Beauty Shop/Utility Room Renovations	2004	4,626	231	20	231		3,351	45
46	Roof	2005	4,910	246	20	246		3,316	46
47	Rooftop Air Handler - 100 Hallway	2006	9,500		10			9,500	47
48	Doors	2006	6,500		10			6,500	48
49	Bell Tower Restoration	2006	6,935	462	15	462		5,777	49
50	Renovations - wall and ceilings	2006	22,329	1,488	15	1,488		18,606	50
51	Renovations - Electrical	2006	19,033	951	20	951		11,895	51
52	Renovations - painting	2006	1,142		5			1,142	52
53	Renovations - fire dampers	2006	12,726	637	20	637		7,954	53
54	Doors	2007	7,033		10			7,033	54
55	Rooftop Air Handler	2007	9,500	475	20	475		5,463	55
56	Interior Doors	2007	9,508		10			9,508	56
57	Doors	2008	1,152	59	10	59		1,152	57
58	Renovations - Storage Room Electrical	2009	3,895	195	20	195		1,852	58
59	Renovations - Occup Therapy Structural Design Work Walls	2009	3,460	230	15	230		2,190	59
60	Heating and Cooling Unit	2009	31,460	2,097	15	2,097		19,922	60
61	Renovations -painting/flooring Occup Therapy	2009	4,574		5			4,574	61
62	Renovations - Occup Therapy Kwik Wall Accordion Door	2009	5,535	369	15	369		3,506	62
63	Renovations - Occup Therapy Carpentry Work Walls	2009	7,911	528	15	528		5,011	63
64	Soffit/Fascia North Entrance	2010	3,971	199	20	199		1,692	64
65	Chapel Entrance Construction	2010	16,610	831	20	831		7,061	65
66	Schematic Design Svcs	2010	31,268	2,085	15	2,085		17,722	66
67	Sidewalk	2012	7,000	467	15	467		3,035	67
68	Renovations - Construction Work Patient Rooms	2012	2,980,629	157,829	20	157,829		1,025,890	68
69	Renovations - Engineering Work Patient Rooms	2012	229,814	15,321	15	15,321		99,586	69
70	TOTAL (lines 4 thru 69)		\$ 5,333,689	\$ 196,218		\$ 196,218	\$	\$ 3,155,335	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 5,333,689	\$ 196,218		\$ 196,218	\$	\$ 3,155,335		1
2	IDPH Plan Review - Patient Room Renovations	2012 11,000	733	15	733		4,765		2
3	Professional Design Services - Patient Room Renovations	2012 177,717	11,850	15	11,850		77,019		3
4	Renovations - Construction Work Patient Rooms	2013 1,928,633	96,430	20	96,430		530,369		4
5	Roof	2013 183,518	9,176	20	9,176		50,468		5
6	Renovations - Bathtubs	2013 12,440	622	20	622		3,421		6
7	Renovations - Construction Work Patient Rooms	2014 797,776	39,890	20	39,890		179,505		7
8	Renovations - Meecho shades, cornice board, step cornice	2014 11,090	2,218	5	2,218		9,981		8
9	Renovation - Courtyard Drainage and Plants	2016 14,075	1,408	10	1,408		4,224		9
10									10
11	Adjustment to understated depreciation expense		2,484		2,484		2,484		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	TOTAL (lines 1 thru 33)	\$ 8,469,938	\$ 361,029		\$ 361,029	\$	\$ 4,017,571		34

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

Facility Name & ID Number Memorial Care Center

003103

Report Period Beginning:

1/01/2018

Ending:

12/31/2018

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	\$ 3,830,142	\$ 228,856	\$	\$ (228,856)		\$ 685,629	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,830,142	\$ 228,856	\$	\$ (228,856)		\$ 685,629	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				\$	\$	\$	\$		\$	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)	\$ 12,387,814	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 589,885	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 361,029	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (228,856)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,703,200	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		\$	\$	\$	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

003103

Report Period Beginning: 1/01/2018

Ending: 12/31/2018

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

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 66,338 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	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		25426.75 hrs	\$ 684,032		\$	2,431	25,427	\$ 686,462	1
2	Licensed Speech and Language Development Therapist		5024.26 hrs	214,377			(280)	5,024	214,097	2
3	Licensed Recreational Therapist		4386.84 hrs	151,247				4,387	151,247	3
4	Licensed Physical Therapist		27458.84 hrs	823,535			1,957	27,459	825,493	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts	333,623			522,751		856,374	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			\$ 2,206,813		\$	\$ 526,859	62,297	\$ 2,733,672	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

003103

Report Period Beginning: 1/01/2018

Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

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	\$ 14,399,679	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>68,761,233</u>)	30,311,018		3
4	Supply Inventory (priced at)	2,623,349		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	406,095		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Receivables</u>	3,574,504		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 51,314,645	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,164,049		12
13	Land	1,930,000		13
14	Buildings, at Historical Cost	41,777,616		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	40,232,751		16
17	Accumulated Depreciation (book methods)	(33,422,772)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP)	18,788,960		22
23	Other(specify): <u>Land Imp + Other Assets</u>	3,698,549		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 74,169,153	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 125,483,798	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,864,192	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,562,081		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	1,637,719		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Payroll w/h</u>	3,159,234		36
37	<u>Accrued PTO, Benefits and Other</u>	40,582,456		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 49,805,682	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	39,600,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Self Insurance Professional Liability</u>	6,058,050		43
44	<u>Accrue Enviro Liab, LT Accrual W.C.</u>	1,886,265		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 47,544,315	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 97,349,997	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 28,133,801	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 125,483,798	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 30,451,598	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 30,451,598	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	283,285	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	(2,601,082)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,317,797)	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)	\$ 28,133,801	24 *

* This must agree with page 17, line 47.

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,959,601	1
2	Discounts and Allowances for all Levels	(38,540,044)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ (31,580,443)	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	26,488,752	6
7	Oxygen	2,748,515	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 29,237,267	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	9,814,820	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,871,732	19
20	Radiology and X-Ray	376,925	20
21	Other Medical Services	210,748	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 14,274,225	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)	\$ 11,931,049	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services		31
32	Health Care		32
33	General Administration		33
B. Capital Expense			
34	Ownership		34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	40
41	Income before Income Taxes (line 30 minus line 40)**	11,931,049	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 11,931,049	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ (79,307)	44
45	Private Pay - Net Inpatient Revenue	(572)	45
46	Medicare - Net Inpatient Revenue	(20,546,039)	46
47	Other-(specify) <u>All Other Payor</u>	(10,954,525)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ (31,580,443)	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

003103

Report Period Beginning:

1/01/2018

Ending:

12/31/2018

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	3,883	4,268	\$ 213,942	\$ 50.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	52,363	59,407	2,241,334	37.73	3
4	Licensed Practical Nurses	12,324	13,654	351,763	25.76	4
5	CNAs & Orderlies	66,092	73,712	1,225,569	16.63	5
6	CNA Trainees	1,892	2,206	32,130	14.56	6
7	Licensed Therapist	21,072	22,715	910,349	40.08	7
8	Rehab/Therapy Aides	38,241	41,791	1,064,095	25.46	8
9	Activity Director	1,901	2,101	42,917	20.43	9
10	Activity Assistants	1,233	1,340	18,824	14.05	10
11	Social Service Workers	2,877	3,158	78,823	24.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	39,029	39,166	746,574	19.06	15
16	Dishwashers					16
17	Maintenance Workers	3,468	3,468	78,360	22.60	17
18	Housekeepers	10,715	11,702	144,879	12.38	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	6,266	7,182	109,479	15.24	22
23	Office Manager					23
24	Clerical	1,565	1,738	28,455	16.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	39	39	6,396	164.00	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	12,512	12,512	465,729	37.22	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	275,472	300,159	\$ 7,759,618 *	\$ 25.85	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	2,720	\$ 201,838	L. 10; C. 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	3,324	77,258	L. 10; C. 3	52
53	TOTAL (lines 50 - 52)	6,044	\$ 279,095		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	
Dr. Michele VanHorn	Medical Director		\$ 6,396	Workers' Compensation Insurance	\$ 50,546	IDPH License Fee	\$	
				Unemployment Compensation Insurance	0	Advertising: Employee Recruitment		
				FICA Taxes	467,074	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	633,101	Patient Background Checks		
				Employee Meals	2,911			
				Illinois Municipal Retirement Fund (IMRF)*				
				Dental	25,973			
				Pension	298,633			
				Life, Long Term and Short Term Ins	89,104			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 6,396	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,567,342		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Nursing-travel/mileage for seminars/mtgs	631
							Seminar Expense	
							Nursing seminars	2,239
							Therapists-seminars	699
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
								\$ 3,569

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Memorial Care Center# 003103Report Period Beginning: 1/01/2018Ending: 12/31/2018**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. \$ 12,455 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. \$ 73,577
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. \$ 2,911 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 310,226
- (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 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