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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 003103

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: 3/01/1964

Type of Ownership:

- [x] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Karen Kurre **Telephone Number:** 314-362-0323
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 1/01/2017 to 12/31/2017 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) 4/27/2018
(Type or Print Name) Michael McManus
(Title) VP-Operations

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 # 003103 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	38	29	24,353	24,420	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38	29	24,353	24,420	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.59%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 3/03/1964

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 15,596

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Memorial Care Center # 003103 **Report Period Beginning:** 1/01/2017 **Ending:** 12/31/2017

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	443,032		20,888	463,920	(18,489)	445,431		445,431			1
2	Food Purchase		323,249		323,249		323,249		323,249			2
3	Housekeeping	127,314	33,828	113,308	274,450	(108,073)	166,377		166,377			3
4	Laundry					73,644	73,644	101,711	175,355			4
5	Heat and Other Utilities			88,022	88,022	730	88,752		88,752			5
6	Maintenance	66,228	2,411	40,701	109,340	(2,086)	107,254		107,254			6
7	Other (specify):*											7
8	**TOTAL General Services**	636,574	359,488	262,919	1,258,981	(54,274)	1,204,707	101,711	1,306,418			8
	B. Health Care and Programs											
9	Medical Director					5,576	5,576		5,576			9
10	Nursing and Medical Records	4,382,244	363,704	1,016,655	5,762,603	(983,553)	4,779,050	720,100	5,499,150			10
10a	Therapy	1,729,985	12,563	397,571	2,140,119	(390,726)	1,749,393	2,924,844	4,674,237			10a
11	Activities	56,276		24,613	80,889	(18,432)	62,457		62,457			11
12	Social Services	68,105		10,628	78,733	(10,533)	68,200		68,200			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,236,610	376,267	1,449,467	8,062,344	(1,397,668)	6,664,676	3,644,944	10,309,620			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	103,512	17	60,905	164,434	441	164,875	2,596,308	2,761,183			21
22	Employee Benefits & Payroll Taxes			(4,782)	(4,782)	1,282,039	1,277,257	68,269	1,345,526			22
23	Inservice Training & Education											23
24	Travel and Seminar			166	166	2,198	2,364		2,364			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			50,790	50,790		50,790		50,790			26
27	Other (specify):* Depr			142,414	142,414	(142,414)						27
28	**TOTAL General Administration**	103,512	17	249,493	353,022	1,142,264	1,495,286	2,664,577	4,159,863			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,976,696	735,772	1,961,879	9,674,347	(309,678)	9,364,669	6,411,232	15,775,901			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: 1/01/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation					313,385	313,385	202,124	515,509			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			425,344	425,344		425,344	(425,344)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					1,890	1,890		1,890			34
35	Rent-Equipment & Vehicles					31,092	31,092		31,092			35
36	Other (specify):*											36
37	**TOTAL Ownership**			425,344	425,344	346,367	771,711	(223,220)	548,491			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	378,398	7,192	168,923	554,513	(10,731)	543,782	91,692	635,474			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,359	97,359		97,359		97,359			42
43	Other (specify):* **Pharmacy**	351,377	561,552	27,008	939,937	(25,958)	913,979	809,764	1,723,743			43
44	**TOTAL Special Cost Centers**	729,775	568,744	293,290	1,591,809	(36,689)	1,555,120	901,456	2,456,576			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,706,471	1,304,516	2,680,513	11,691,500		11,691,500	7,089,468	18,780,968			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 # 003103 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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)	7,089,468		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 7,089,468		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 7,089,468		37

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

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

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

Memorial Care Center

ID# 003103

Report Period Beginning: 1/01/2017

Ending: 12/31/2017

	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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Memorial Care Center # 003103 **Report Period Beginning:** 1/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	101,711	0	0	0	0	0	0	0	0	0	101,711	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	101,711	0	0	0	0	0	0	0	0	0	101,711	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	720,100	0	0	0	0	0	0	0	0	0	720,100	10
10a	Therapy	0	2,924,844	0	0	0	0	0	0	0	0	0	2,924,844	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	3,644,944	0	0	0	0	0	0	0	0	0	3,644,944	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	2,596,308	0	0	0	0	0	0	0	0	0	2,596,308	21
22	Employee Benefits & Payroll Taxes	0	68,269	0	0	0	0	0	0	0	0	0	68,269	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	2,664,577	0	0	0	0	0	0	0	0	0	2,664,577	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	6,411,232	0	0	0	0	0	0	0	0	0	6,411,232	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Memorial Care Center** **#** **003103** **Report Period Beginning:** **1/01/2017** **Ending:** **12/31/2017**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	202,124	0	0	0	0	0	0	0	0	0	202,124	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(425,344)	0	0	0	0	0	0	0	0	0	(425,344)	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	(223,220)	0	0	0	0	0	0	0	0	0	(223,220)	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	91,692	0	0	0	0	0	0	0	0	0	91,692	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	809,764	0	0	0	0	0	0	0	0	0	809,764	43
44	**TOTAL Special Cost Centers**	0	901,456	0	0	0	0	0	0	0	0	0	901,456	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	7,089,468	0	0	0	0	0	0	0	0	0	7,089,468	45

Facility Name & ID Number Memorial Care Center # 003103 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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. [x] 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, CAT, Lab, RT, Cardio	$ 543,782	Memorial Hospital		$ 635,474	$ 91,692	1
2	V	10a	Therapies	1,749,393			4,674,237	2,924,844	2
3	V	43	Pharmacy	913,979			1,723,743	809,764	3
4	V	32	Allowable Interest Expense	425,345			1	(425,344)	4
5	V	30	Depreciation	313,385			515,509	202,124	5
6	V	21	A&G Overhead allocations from hospit	1			2,596,309	2,596,308	6
7	V	4	Laundryoverhead allocation from hosp	1			101,712	101,711	7
8	V	22	Employee meals from hosp.cafeteria	1			68,270	68,269	8
9	V	10	Nurs Adm & Med Rec overhead alloc fi	1			720,101	720,100	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 3,945,888			$ 11,035,356	$ * 7,089,468	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: 1/01/2017 Ending: 12/31/2017

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								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

Facility Name & ID Number Memorial Care Center # 003103 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 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: 1/01/2017 Ending: 2/31/2017

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 [ ]

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 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	66,145,961	2	$ 8,331,086	$ 2,839,148	436,056	$ 54,921	1
2	39	CAT Scan	revenue	95,382,140	2	1,985,601	559,999	60,024	1,250	2
3	39	Laboratory	revenue	150,819,158	2	12,166,804	4,033,211	3,290,656	265,462	3
4	39	Respiratory Therapy	revenue	40,525,186	2	4,116,047	1,711,542	2,923,401	296,923	4
5	39	Cardiology	revenue	53,496,341	2	3,320,067	1,368,588	199,159	12,360	5
6	39	MRI	revenue	18,140,336	2	1,369,362	272,035	60,381	4,558	6
7	10a	Physical Therapy	revenue	45,701,058	2	8,739,201	4,990,491	14,879,381	2,845,315	7
8	10a	Occupational Therapy	revenue	12,855,940	2	2,101,274	1,233,676	8,179,720	1,336,957	8
9	10a	Speech Therapy	revenue	4,065,067	2	1,169,456	680,032	1,710,085	491,965	9
10	43	Drugs	revenue	98,375,373	2	15,538,859	3,578,167	10,912,891	1,723,743	10
11	32	Interest Expense	actual	0	2	0	0	0		11
12	30	Depreciation	actual	526,559	2	526,559	0	515,509	515,509	12
13	21	Communications	phones	1,763	2	586,426	193,181	51	16,964	13
14	21	Data Processing	resources	9,154	2	7,982,168	50,717	376	327,867	14
15	21	Purchasinsg	requisitions	1,691,150	2	547,424	22,034	43,066	13,940	15
16	21	Admitting	pt days	77,803	2	1,156,513	869,793	24,420	362,994	16
17	21	Patient Accounts	gross chgs	984,847,104	2	2,594,896	1,480,970	6,606,566	17,407	17
18	21	Admin & General	accumulated cost	180,690,322	2	39,303,289	6,617,863	8,537,879	1,857,137	18
19	4	Laundry	pounds	913,375	2	956,164	0	97,160	101,712	19
20	22	Cafeteria-empl meals	empl meals	85,063	2	1,035,893	427,520	5,606	68,270	20
21	10	Nursing Admin	time spent	909,559	2	6,706,536	3,014,785	50,817	374,694	21
22	10	Medical Records	time spent	16,046	2	1,904,603	556,674	2,910	345,407	22
23										23
24										24
25	TOTALS					$ 122,138,228	$ 34,500,426		$ 11,035,355	25

Facility Name & ID Number Memorial Care Center # 003103 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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 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.)**

Facility Name & ID Number Memorial Care Center **#** 003103 **Report Period Beginning:** 1/01/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2017 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:			
	2012		**8**
	2013		**9**
	2014		**10**
	2015		**11**
	2016		**12**

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	**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.

2016 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 ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 1/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,001 B. General Construction Type: Exterior Brick Frame _____ 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1964	$ 87,734	1
2					2
3	TOTALS			$ 87,734	3

Facility Name & ID Number Memorial Care Center # 003103 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	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		88,879	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		2,372	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		3,459	23
24	Electrical work			2001	16,778	838	20	838		13,839	24
25	Window replacement			2002	113,345	3,777	15	3,777		113,345	25
26	Storage addition			2002	253,195	8,435	15	8,435		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	149	15	149		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	17	15	17		490	32
33	Fire Alarm/Nurse Call Replacement			2002	61,775	3,091	20	3,091		47,883	33
34	Patient Wardrobe Units			2002	67,813	2,258	15	2,258		67,813	34
35	Patient Wardrobe Units			2002	5,824		10			5,824	35
36	Heating and Cooling Unit			2002	7,702	256	15	256		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: 1/01/2017 Ending: 12/31/2017

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	8" Faucets	2002	$ 5,318	$ 266	20	$ 266	$	$ 4,123	37
38	Window Replacement	2003	75	7	15	7		75	38
39	Storage Addition	2003	138	9	15	9		132	39
40	Fire Alarm/Nurse Call Replacement	2003	659		10			659	40
41	Window Replacement	2003	16,451	1,097	15	1,097		15,905	41
42	Patient Wardrobe Units	2003	16,789	840	20	840		12,173	42
43	Fire Alarm/Nurse Call Replacement	2003	19,745	988	20	988		14,315	43
44	Utility Storage Room Plumbing Work	2004	776	38	20	38		520	44
45	Beauty Shop/Utility Room Renovations	2004	4,626	231	20	231		3,120	45
46	Roof	2005	4,910	246	20	246		3,070	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		5,315	49
50	Renovations - wall and ceilings	2006	22,329	1,488	15	1,488		17,118	50
51	Renovations - Electrical	2006	19,033	951	20	951		10,944	51
52	Renovations - painting	2006	1,142		5			1,142	52
53	Renovations - fire dampers	2006	12,726	637	20	637		7,317	53
54	Doors	2007	7,033	353	10	353		7,033	54
55	Rooftop Air Handler	2007	9,500	475	20	475		4,988	55
56	Interior Doors	2007	9,508	475	10	475		9,508	56
57	Doors	2008	1,152	115	10	115		1,093	57
58	Renovations - Storage Room Electrical	2009	3,895	195	20	195		1,657	58
59	Renovations - Occup Therapy Structural Design Work Walls	2009	3,460	230	15	230		1,960	59
60	Heating and Cooling Unit	2009	31,460	2,097	15	2,097		17,825	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		3,137	62
63	Renovations - Occup Therapy Carpentry Work Walls	2009	7,911	528	15	528		4,483	63
64	Soffit/Fascia North Entrance	2010	3,971	199	20	199		1,493	64
65	Chapel Entrance Construction	2010	16,610	831	20	831		6,230	65
66	Schematic Design Svcs	2010	31,268	2,085	15	2,085		15,637	66
67	Sidewalk	2012	7,000	467	15	467		2,568	67
68	Renovations - Construction Work Patient Rooms	2012	2,980,629	157,829	20	157,829		868,061	68
69	Renovations - Engineering Work Patient Rooms	2012	229,814	15,321	15	15,321		84,265	69
70	TOTAL (lines 4 thru 69)		$ 5,333,689	$ 212,545		$ 212,545	$	$ 2,959,117	70

**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: 1/01/2017 Ending: 12/31/2017

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		$ 5,333,689	$ 212,545		$ 212,545	$	$ 2,959,117	1
2	IDPH Plan Review - Patient Room Renovations	2012	11,000	733	15	733		4,032	2
3	Professional Design Services - Patient Room Renovations	2012	177,717	11,850	15	11,850		65,169	3
4	Renovations - Construction Work Patient Rooms	2013	1,928,633	96,430	20	96,430		433,939	4
5	Roof	2013	183,518	9,176	20	9,176		41,292	5
6	Renovations - Bathtubs	2013	12,440	622	20	622		2,799	6
7	Renovations - Construction Work Patient Rooms	2014	797,776	39,890	20	39,890		139,615	7
8	Renovations - Meecho shades, cornice board, step cornice	2014	11,090	2,218	5	2,218		7,763	8
9	Renovation - Courtyard Drainage and Plants	2016	14,075	1,408	10	1,408		2,816	9
10									10
11	Adjustment to overstated depreciation expense			(128,821)		(128,821)		(128,821)	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	$ 246,051		$ 246,051	$	$ 3,527,721	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: 1/01/2017 Ending: 12/31/2017

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	$ 739,998	$ 95,504	$ 95,504	$		$ 325,082	71
72	Current Year Purchases	12,945	1,695	1,695			8,823	72
73	Fully Depreciated Assets	768,357					768,357	73
74	Adjustment to overstated dep		(29,865)	(29,865)			(29,865)	74
75	TOTALS	$ 1,521,300	$ 67,334	$ 67,334	$		$ 1,072,397	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		2000 Ford Bus	2000	$ 49,174	$	$	$	4	$ 49,174	76
77										77
78										78
79										79
80	TOTALS			$ 49,174	$	$	$		$ 49,174	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)	$ 10,128,146	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 313,385	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 313,385	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)	$ 4,649,292	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: 1/01/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 31,092 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.

Facility Name & ID Number Memorial Care Center # 003103 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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.

Facility Name & ID Number Memorial Care Center # 003103 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	$ 630,835		$	$ 1,880		$ 632,715	1
2	Licensed Speech and Language Development Therapist	10a	hrs	204,370			5,508		209,878	2
3	Licensed Recreational Therapist	11	hrs	56,276					56,276	3
4	Licensed Physical Therapist	10a	hrs	894,779			5,175		899,954	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	351,377			561,552		912,929	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			$ 2,137,637		$	$ 574,115		$ 2,711,752	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.

STATE OF ILLINOIS

Facility Name & ID Number Memorial Care Center **#** 003103 **Report Period Beginning:** 1/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2017 **(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	$ 42,878,831	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 62,232,884)	31,304,954		3
4	Supply Inventory (priced at)	2,545,967		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	368,089		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): other receivables	5,120,203		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 82,218,044	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	26,062,301		12
13	Land	1,930,000		13
14	Buildings, at Historical Cost	39,390,937		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	37,184,433		16
17	Accumulated Depreciation (book methods)	(22,498,830)		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	13,748,774		22
23	Other(specify): Land improve.+ other assets	3,839,965		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 99,657,580	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 181,875,624	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,878,917	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,986,733		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	1,404,719		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accrued payroll w/h	2,587,057		36
37	accrued PTO,benefits & other	94,262,264		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 104,119,690	$	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	self-ins prof liability	5,448,220		43
44	accr.environ liab & LT accr W.C.	2,256,116		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 47,304,336	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 151,424,026	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 30,451,598	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 181,875,624	$	48

***(See instructions.)**

Facility Name & ID Number Memorial Care Center # 003103 **Report Period Beginning:** 1/01/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 39,905,743	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 39,905,743	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	352,736	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**	(9,806,881)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (9,454,145)	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)**	$ 30,451,598	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Memorial Care Center # 003103 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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	$ 6,606,566	1
2	Discounts and Allowances for all Levels	(37,215,704)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (30,609,138)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	24,769,186	6
7	Oxygen	2,923,401	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 27,692,587	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	10,912,891	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,290,656	19
20	Radiology and X-Ray	556,461	20
21	Other Medical Services	199,457	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,959,465	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	other misc	1,322	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,322	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,044,236	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,204,707	31
32	Health Care	6,659,059	32
33	General Administration	1,500,903	33
	B. Capital Expense		
34	Ownership	771,711	34
	C. Ancillary Expense		
35	Special Cost Centers	1,457,761	35
36	Provider Participation Fee	97,359	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,691,500	40
41	**Income before Income Taxes (line 30 minus line 40)****	352,736	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 352,736	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ (49,247)	44
45	Private Pay - Net Inpatient Revenue	(36,800)	45
46	Medicare - Net Inpatient Revenue	(19,614,287)	46
47	Other-(specify) all other payers	(10,908,804)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ (30,609,138)	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: 1/01/2017 Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,207	2,467	$ 106,102	$ 43.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	52,958	57,391	2,314,767	40.33	3
4	Licensed Practical Nurses	10,021	10,999	264,421	24.04	4
5	CNAs & Orderlies	67,264	72,787	1,251,219	17.19	5
6	CNA Trainees					6
7	Licensed Therapist	15,780	17,335	710,462	40.98	7
8	Rehab/Therapy Aides	36,395	40,038	986,960	24.65	8
9	Activity Director	1,846	2,044	40,642	19.88	9
10	Activity Assistants	1,088	1,176	17,507	14.89	10
11	Social Service Workers	2,536	2,790	68,105	24.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	33,503	36,041	443,032	12.29	15
16	Dishwashers					16
17	Maintenance Workers	2,956	3,179	66,228	20.83	17
18	Housekeepers	10,539	11,455	127,314	11.11	18
19	Laundry					19
20	Administrator	2,877	3,217	138,324	43.00	20
21	Assistant Administrator					21
22	Other Administrative	3,681	4,119	173,063	42.02	22
23	Office Manager					23
24	Clerical	12,727	13,983	262,973	18.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	34	34	5,576	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)	18,024	19,381	729,776	37.65	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	274,436	298,436	$ 7,706,471 *	$ 25.82	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	6,573	$ 476,954	L. 10; C. 3	50
51	Licensed Practical Nurses	5,082	114,454	L. 10; C. 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	11,655	$ 591,408		53

Facility Name & ID Number Memorial Care Center # 003103 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dr. Michele VanHorn	Medical Director		$ 4,961
Dr. T. Hipskind			615
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 5,576

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	$ 45,410
Unemployment Compensation Insurance	
FICA Taxes	425,054
Employee Health Insurance	532,093
Employee Meals	68,269
Illinois Municipal Retirement Fund (IMRF)*	
Pension	216,534
Life & Disability Ins	58,166
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,345,526

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

Description	Line #	Amount
		$
TOTAL		$

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	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Admin - travel/mileage for seminars/mtgs	166
Nursing-travel/mileage for seminars/mtgs	961
Therapist-travel/mileage for seminars/mtgs	93
Seminar Expense	
Nursing seminars	315
Therapists-sseminars	829
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,364

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Memorial Care Center # 003103 Report Period Beginning: 1/01/2017 Ending: 12/31/2017

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 politica
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. $ **14,546** 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 fo
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 Departmen
during this cost report period. $ **97,359**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **68,269** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **338,070**

(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 fo
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? **NA**
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? **NA**
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? **Yes**
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. **NA**
Attach invoices and a summary of services for all architect and appraisal fees