

Facility Name & ID Number Hamilton Memorial Rehabilitation & Heath Care Center

0051292 Report Period Beginning: 1/1/2018 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 _____

	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	60	Skilled (SNF)	60	21,900	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	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,524	6,031	2,035	16,590	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,524	6,031	2,035	16,590	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.75%

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 5/17/2011

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/17/2011 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 60 and days of care provided 1,368

Medicare Intermediary Wisconsin Physician 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 Hamilton Memorial Rehabilitation & Health C # 0051292 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	179,038	19,045	650	198,733		198,733		198,733		1
2	Food Purchase		100,532		100,532		100,532	(566)	99,966		2
3	Housekeeping		16,069	72,786	88,855		88,855		88,855		3
4	Laundry		5,013	48,525	53,538		53,538		53,538		4
5	Heat and Other Utilities			108,316	108,316		108,316		108,316		5
6	Maintenance	29,791	5,619	25,479	60,889		60,889		60,889		6
7	Other (specify):*										7
8	TOTAL General Services	208,829	146,278	255,756	610,863		610,863	(566)	610,297		8
	B. Health Care and Programs										
9	Medical Director					13,000	13,000		13,000		9
10	Nursing and Medical Records	930,500	40,575	21,342	992,417	(13,000)	979,417		979,417		10
10a	Therapy										10a
11	Activities	14,679	1,817	32,674	49,170		49,170		49,170		11
12	Social Services	34,570		4,337	38,907		38,907		38,907		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	979,749	42,392	58,353	1,080,494		1,080,494		1,080,494		16
	C. General Administration										
17	Administrative	79,911			79,911		79,911		79,911		17
18	Directors Fees										18
19	Professional Services			68,442	68,442		68,442	162,905	231,347		19
20	Dues, Fees, Subscriptions & Promotions			11,386	11,386		11,386	(1,459)	9,927		20
21	Clerical & General Office Expenses	54,810	17,211	167,532	239,553		239,553	(141,551)	98,002		21
22	Employee Benefits & Payroll Taxes			206,081	206,081		206,081		206,081		22
23	Inservice Training & Education			150	150		150		150		23
24	Travel and Seminar			1,443	1,443		1,443		1,443		24
25	Other Admin. Staff Transportation			7,824	7,824		7,824	(5,540)	2,284		25
26	Insurance-Prop.Liab.Malpractice			79,045	79,045		79,045		79,045		26
27	Other (specify):*										27
28	TOTAL General Administration	134,721	17,211	541,903	693,835		693,835	14,355	708,190		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,323,299	205,881	856,012	2,385,192		2,385,192	13,789	2,398,981		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			12,316	12,316		12,316	33,244	45,560			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,913	7,913		7,913	(7,913)				32
33	Real Estate Taxes			53	53		53		53			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(180,000)				34
35	Rent-Equipment & Vehicles			3,872	3,872		3,872		3,872			35
36	Other (specify):*											36
37	TOTAL Ownership			204,154	204,154		204,154	(154,669)	49,485			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,224	323,395	368,619		368,619		368,619			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,029	126,029		126,029		126,029			42
43	Other (specify):* Marketing	37,969		25,035	63,004		63,004	(63,004)				43
44	TOTAL Special Cost Centers	37,969	45,224	474,459	557,652		557,652	(63,004)	494,648			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,361,268	251,105	1,534,625	3,146,998		3,146,998	(203,884)	2,943,114			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	(566)	02		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	13,373	30		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	(10,252)	21		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	16,398	21		24
25	Fund Raising, Advertising and Promotional	(25,035)	43		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	(44,968)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,050)		\$	30

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)	(152,834)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (152,834)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (203,884)		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

BHF USE ONLY							
48		49		50		51	52

Hamilton Memorial Rehabilitation & Health Care Center

ID# 0051292

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lobbying Dues	\$ (1,091)	20	1
2	PAC Dues	(288)	20	2
3	Marketing Salaries	(37,969)	43	3
4	Marketing Petty Cash	(80)	20	4
5	Marketing Mileage	(5,540)	25	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	(44,968)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hamilton Memorial Rehabilitation & Health Care Center

0051292

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(566)	0	0	0	0	0	0	0	0	0	0	(566)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	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	(566)	0	0	0	0	0	0	0	0	0	0	(566)	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	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	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	2,890	160,015	0	0	0	0	0	0	0	0	162,905	19
20	Fees, Subscriptions & Promotions	(1,459)	0	0	0	0	0	0	0	0	0	0	(1,459)	20
21	Clerical & General Office Expenses	6,146	5	(147,702)	0	0	0	0	0	0	0	0	(141,551)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	(5,540)	0	0	0	0	0	0	0	0	0	0	(5,540)	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	(853)	2,895	12,313	0	0	0	0	0	0	0	0	14,355	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,419)	2,895	12,313	0	0	0	0	0	0	0	0	13,789	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hamilton Memorial Rehabilitation & Health Care Center # 0051292 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	13,373	16,319	3,552	0	0	0	0	0	0	0	0	33,244	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	(7,913)	0	0	0	0	0	0	0	0	(7,913)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(180,000)	0	0	0	0	0	0	0	0	0	(180,000)	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	13,373	(163,681)	(4,361)	0	0	0	0	0	0	0	0	(154,669)	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	0	0	0	0	0	0	0	0	0	0	0	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):*	(63,004)	0	0	0	0	0	0	0	0	0	0	(63,004)	43
44	TOTAL Special Cost Centers	(63,004)	0	0	0	0	0	0	0	0	0	0	(63,004)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(51,050)	(160,786)	7,952	0	0	0	0	0	0	0	0	(203,884)	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
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 180,000	TI-McLeansboro		\$	(180,000)	1
2	V	19 Legal/Accounting		TI-McLeansboro		2,890	2,890	2
3	V	30 Depreciation		TI-McLeansboro		16,319	16,319	3
4	V	21 Miscellaneou		TI-McLeansboro		5	5	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 180,000			\$ 19,214	\$ * (160,786)	14

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

VII. RELATED PARTIES (continued)

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)
15	V	21 Management Fee	\$ 147,702	Tutera Health Care Services	100.00%	\$	(147,702)
16	V	19 Management - Operating	27,054	Tutera Health Care Services	100.00%	187,069	160,015
17	V	30 Management - Depreciation		Tutera Health Care Services	100.00%	3,552	3,552
18	V	2 Dietary Small Equip	188	Walnut Creek Management		188	
19	V	10 Nursing Supplies	127	Walnut Creek Management		127	
20	V	19 Legal/Data Processing	243	Walnut Creek Management		243	
21	V	20 Employee Want Ads/Licenses	3,001	Walnut Creek Management		3,001	
22	V	21 Small Equip/Postage/Entertainment	6,415	Walnut Creek Management		6,415	
23	V	25 Travel & Seminar	597	Walnut Creek Management		597	
24	V	43 Advertising	60	Walnut Creek Management		60	
25	V	22 Insurance	3,707	CarePlus Insurance, Inc		3,707	
26	V	26 Insurance	70,238	LTC Plus Insurance, Inc.		70,238	
27	V	32 Interest	7,913	JCT Capital, Inc			(7,913)
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 267,245			\$ 275,197	\$ * 7,952

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

Facility Name & ID Number

Hamilton Memorial Rehabilitation & Health Care Center

0051292

Report Period Beginning:

1/1/2018

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	JCT FLP, LLC	99%	Auburn Rehab & Health Care Center	Auburn, IL	The Atriums Senior Li	Overland Park, KS	IL/AL	1
2	JCT INV, LLC	1%	Windsor Rehab & Health Care Center	Terrell, TX	Carnegie Village Senio	Belton, MO	IL/AL	2
3			Bethany Rehab & Health Care Center	DeKalb, IL	Continua Home Health	Kansas City, MO	Home Health	3
4			Carlinville Rehab & Health Care Center	Carlinville, IL	Country Gardens Assi	Muskogee, OK	AL	4
5			Coulterville Rehab & Health Care Center	Coutlerville, IL	Lamar Court Assisted	Overland Park, KS	AL	5
6			Crystal Pines Rehab & Health Care Center	Crystal Lake, IL	Oakley Court Assisted	Freeport, IL	AL	6
7			Dixon Rehab & Health Care Center	Dixon, IL	Rose Estates Assisted I	Overland Park, KS	AL	7
8			Fair Oaks Rehab & Health Care Center	South Beloit, IL	Stratford Commons M	Overland Park, KS	Memory Care	8
9			Highland Rehab & Health Care Center	Kansas City, MO	Vicotry Hills Senior Li	Kansas City, MO	IL/AL	9
10			Hillsboro Rehab & Health Care Center	Hillsboro, IL	Wesley Court Assisted	Boiling Springs, SC	AL	10
11			Lakeland Rehab & Health Care Center	Effingham, IL	Willow Place Assisted	Laurinburg, NC	AL	11
12			Mattoon Rehab & Health Care Center	Mattoon, IL	Bright Oaks of Aurora	Aurora, IL	AL	12
13			Meridian Rehab & Health Care Center	Wichita, KS	Pardise Park Assisted	Fox Lake, IL	AL	13
14			Metropolis Rehab & Health Care Center	Metropolis, IL	TI McLeansboro	McLeansboro, IL	Building Company	14
15			Monterey Park Rehab & Health Care Center	Independence, MO	Columbia 7611 LLC	Kansas City, MO	Building Company	15
16			Montgomery Children's Specialty Center	Montgomery, AL	Tutera Health Care Se	Kansas City, MO	Mgmt Company	16
17			Charlton Place Rehab & Health Care Center	Deatsville, AL	CarePlus Health Plans	Kansas City, MO	Insurance Company	17
18			Westridge Gardens Rehab & Health Care Cente	Raytown, MO	Walnut Creek Manage	Kansas City, MO	Mgmt Company	18
19			Willow Care Rehab & Health Care Center	Hannibal, MO	Walnut Creek New En	Kansas City, MO	Mgmt Company	19
20			Holly Hill Rehab & Health Care Center	Sulphur, LA	Tutera Investments In	Kansas City, MO	Mgmt Company	20
21			Rosewood Rehab & Health Care Center	Lake Charles, LA	JCT Capital Inc	Kansas City, MO	Mgmt Company	21
22			St. Paul's Senior Community	Belleville, IL	Tutera Group Inc	Kansas City, MO	Mgmt Company	22
23			Greenfield Manor	Greenfield, IA	LTC Plus Insurnce Inc	Kansas City, MO	Insurance Company	23
24			Griswold Care Center	Griswold, IA	Residence at Pleasont	Pleasantan	AI/IL	24
25			Moweaqua Rehab & Health Care Center	Moweaqua, IL	Mt Ayr	Mt.Ayr, IA	AL/IL	25
26			Stratford Rehab & Health Care Center	Overland Park KS	Missiona Chateua Sen	Prairie Village, KS	AL/IL	26
27			Carnegie Village Rehab & Health Care Center	Belton, MO				27
28			Tiffany Springs Rehab & Health Care Center	Kansas City, MO				28
29			Northland Rehab & Health Care Center	Kansas City, MO				29
30			Westview of Derby	Derby, KS				30

Facility Name & ID Number Hamilton Memorial Rehabilitation & Health C # 0051292 Report Period Beginning: 1/1/2018 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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Hamilton Memorial Rehabilitation & Health Care Center # 0051292 Report Period Beginning: 1/1/2018 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 Tutera Health Care Services
 Street Address 7611 State Line Road
 City / State / Zip Code Kansas City, MO 64114
 Phone Number (816) 444-0900
 Fax Number (816) 822-0081

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	19	Management Fee - Operating	Direct Costs	193,500,518	48	\$ 12,214,787	\$ 8,837,460	2,963,527	\$ 187,074	1
2	30	Management Fee - Depreciation	Direct Costs	193,500,518	48	231,947		2,963,527	3,552	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	TOTALS					\$ 12,446,734	\$ 8,837,460		\$ 190,626	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	JCT Capital	X		Note Payable			\$ 824,000	\$ 1,118,039		0.0100	\$ 7,913	1								
2	Related Party Offset										(7,913)	2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 824,000	\$ 1,118,039			\$	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 824,000	\$ 1,118,039			\$	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # 36

* 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.		\$	13,034	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.)		\$	13,087	2
3. Under or (over) accrual (line 2 minus line 1).		\$	53	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.		\$	53	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	15,721	8	
	2014	15,769	9	
	2015	12,883	10	
	2016	13,034	11	
	2017	13,087	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Hamilton Memorial Rehabilitation & Heath Care Center COUNTY Hamilton

FACILITY IDPH LICENSE NUMBER 0051292

CONTACT PERSON REGARDING THIS REPORT Kevin Wellen, CPA

TELEPHONE (314) 925-4446 FAX #: (314) 925-4350

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. <u>07-030-005-25</u>	<u>Long-Term Care</u>	\$ <u>13,086.82</u>	\$ <u>13,086.82</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>13,086.82</u></u>	\$ <u><u>13,086.82</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 Hamilton Memorial Rehabilitation & Health Care Center

0051292

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,923 B. General Construction Type: Exterior Brick Frame Wood/Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Long-Term Care</u>	<u>14,923</u>	<u>20011</u>	<u>\$ 28,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	14,923		\$ 28,500	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	60		2011	1970	\$ 399,000	\$ 14,509	27	\$ 14,509		\$ 110,634
5										
6										
7										
8										
	Improvement Type**									
9		THERAPY ROOM	2011		96,066	9,607	10	9,607		67,246
10		LAUNDRY ROOM	2011		22,902	2,290	10	2,290		16,031
11		BREEZEWAY RENOVATION (WINDOWS)	2012		10,460	729	15	729		4,352
12		FLOORING	2014		17,174	1,189	15	1,189		6,469
13		SPRINKLER SYSTEM PIPE INSULATION	2014		7,395	422	20	422		2,184
14		HVAC REPAIRS	2016		6,257	2,086	3	2,086		3,042
15		HVAC REPAIRS	2017		5,519	1,840	3	1,840		2,131
16		20 TON ROOF AC UNIT	2017		21,855	2,186	10	2,186		2,914
17										
18		HOME OFFICE DEPRECIATION				3,552		3,552		
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 586,628	\$ 38,410		\$ 38,410	\$	\$ 215,003	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 70,133	\$ 5,341	\$ 5,341	\$	Various	\$ 60,242	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	61,084	1,809	1,809		Various	61,084	73
74								74
75	TOTALS	\$ 131,217	\$ 7,150	\$ 7,150	\$		\$ 121,326	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		Van	2011	\$ 10,636	\$	\$	\$	5	\$ 10,636	76
77										77
78										78
79										79
80	TOTALS			\$ 10,636	\$	\$	\$		\$ 10,636	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)	\$ 756,981	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,560	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 45,560	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)	\$ 346,965	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

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: \$ 3,872 Description: Copier

(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	V39-3	hrs	\$	1,576	\$ 128,455	\$	1,576	\$ 128,455	1
2	Licensed Speech and Language Development Therapist	V39-3	hrs		734	63,359		734	63,359	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-3	hrs		1,538	119,103	214	1,538	119,317	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				34,959		34,959	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See WTB</u>					12,478	10,051		22,529	13
14	TOTAL			\$	3,848	\$ 323,395	\$ 45,224	3,848	\$ 368,619	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 Hamilton Memorial Rehabilitation & Health Care Center # 0051292 Report Period Beginning: 1/1/2018 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	\$ 180,119	\$ 181,384	1
2	Cash-Patient Deposits	14,829	14,829	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	293,003	293,003	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	81,176	81,176	6
7	Other Prepaid Expenses	146,470	146,470	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 715,597	\$ 716,862	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		28,500	13
14	Buildings, at Historical Cost		399,000	14
15	Leasehold Improvements, at Historical Cost	187,627	187,627	15
16	Equipment, at Historical Cost	94,354	141,854	16
17	Accumulated Depreciation (book methods)	(188,831)	(346,965)	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 (specify):			22
23	Other(specify): <u>Other Long-Term Assets</u>	25,490	24,978	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 118,640	\$ 434,994	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 834,237	\$ 1,151,856	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 287,200	\$ 287,200	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,829	14,829	28
29	Short-Term Notes Payable	1,118,039	1,118,039	29
30	Accrued Salaries Payable	113,601	113,601	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,320	27,320	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Management Fee Payable</u>	(59)	(59)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,560,930	\$ 1,560,930	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany</u>	27,909	27,909	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 27,909	\$ 27,909	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,588,839	\$ 1,588,839	46
47	TOTAL EQUITY(page 18, line 24)	\$ (754,602)	\$ (436,983)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 834,237	\$ 1,151,856	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (564,142)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (564,142)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(187,842)	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	(2,620)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (190,462)	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)	\$ (754,604)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Hamilton Memorial Rehabilitation & Heath Care C** # **0051292** Report Period Beginning: **1/1/2018**Ending: **12/31/2018****XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required****classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,177,626	1
2	Discounts and Allowances for all Levels	(943,291)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,234,335	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,631,776	6
7	Oxygen	21	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,631,797	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	964	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	566	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	70,225	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,799	19
20	Radiology and X-Ray		20
21	Other Medical Services	11,354	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 87,908	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,116	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,116	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)	\$ 2,959,156	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	610,863	31
32	Health Care	1,080,494	32
33	General Administration	693,835	33
B. Capital Expense			
34	Ownership	204,154	34
C. Ancillary Expense			
35	Special Cost Centers	431,623	35
36	Provider Participation Fee	126,029	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,146,998	40
41	Income before Income Taxes (line 30 minus line 40)**	(187,842)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (187,842)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,252,184	44
45	Private Pay - Net Inpatient Revenue	723,904	45
46	Medicare - Net Inpatient Revenue	(699,121)	46
47	Other-(specify)	(42,632)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,234,335	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 Hamilton Memorial Rehabilitation & Heath Care Center

0051292

Report Period Beginning: 1/1/2018

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	1,561	1,669	\$ 51,374	\$ 30.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,128	8,654	228,133	26.36	3
4	Licensed Practical Nurses	12,964	13,833	283,740	20.51	4
5	CNAs & Orderlies	29,326	31,382	363,131	11.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	588	604	10,191	16.87	9
10	Activity Assistants	355	355	4,488	12.64	10
11	Social Service Workers	1,760	2,000	34,570	17.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,157	15,432	179,038	11.60	15
16	Dishwashers					16
17	Maintenance Workers	1,766	1,976	29,791	15.08	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,816	2,000	79,911	39.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,166	3,567	54,810	15.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	333	333	4,122	12.38	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	1,744	1,992	37,969	19.06	33
34	TOTAL (lines 1 - 33)	77,664	83,797	\$ 1,361,268 *	\$ 16.24	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	Monthly	\$ 650	V01-2	35
36	Medical Director	Monthly	13,000	V09-5	36
37	Medical Records Consultant	Monthly	982	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,645	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	32,458	V11-3	44
45	Social Service Consultant	Monthly	4,337	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 56,072		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		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	
Kelly Boggess	Administrator	0	\$ 79,911	Workers' Compensation Insurance	\$ 33,308	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	3,032	
				FICA Taxes	108,274	Health Care Worker Background Check (Indicate # of checks performed <u>54</u>)	548	
				Employee Health Insurance	57,132	Patient Background Checks		
				Employee Meals		IL Health Care Association	3,630	
				Illinois Municipal Retirement Fund (IMRF)*		Walnut Creek Mgmt Co, LLC	800	
				Other Benefits	7,367			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 79,911			Other Dues and Subscriptions	698	
B. Administrative - Other						Other Licenses	2,678	
Description			Amount			Less: Public Relations Expense	(1,459)	
N/A			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 206,081	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,927	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Daniel Maher Law Offices	Legal		\$ 3,147	N/A		\$	Out-of-State Travel	\$
Kotner Title & Abstract LLC	Legal		200					
Other Accurals	Legal		32					
CliftonLarsonAllen LLP	Accounting/Cost Report		13,400				In-State Travel	
Healthcare Information Systems	Data Processing		700					
PointClickCare Technologies Inc	Data Processing		15,325					
Walnut Creek Mgmt Co LLC	Data Processing		31,882				Seminar Expense	1,443
Allscripts Helathcare LLC	Professional Services		2,280					
Pinnacle Quality Insight	Professional Services		1,376					
Property Valuation Services	Professional Services		100				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 68,442	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,443

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hamilton Memorial Rehabilitation & Health Care Center# 0051292Report Period Beginning: 1/1/2018Ending: 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? Yes
If YES, give association name and amount. IL Health Care Association, \$3,630
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? N/A
- (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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,979 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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 126,029
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 566
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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. Yes
Attach invoices and a summary of services for all architect and appraisal fees