

Facility Name & ID Number Mercy Circle

0051201 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	<u>22</u>	Skilled (SNF)	<u>22</u>	<u>8,052</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3		Intermediate (ICF)			<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>22</u>	TOTALS	<u>22</u>	<u>8,052</u>	<u>7</u>

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,669</u>	<u>346</u>	<u>2,607</u>	<u>6,622</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF					<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>3,669</u>	<u>346</u>	<u>2,607</u>	<u>6,622</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.24%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold 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 05/01/2014

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified 22 and days of care provided 2,607

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30 Fiscal Year: 6/30

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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Operating Expenses	Costs 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
	A. General Services										
1	Dietary		3,881	1,166,549	1,170,430		1,170,430	(853,016)	317,414		1
2	Food Purchase										2
3	Housekeeping	147,924	23,992	380	172,296		172,296	(127,023)	45,273		3
4	Laundry			42,735	42,735		42,735	(28,149)	14,586		4
5	Heat and Other Utilities			171,318	171,318		171,318	(136,854)	34,464		5
6	Maintenance	251,655	23,112	218,191	492,958	50	493,008	(396,221)	96,787		6
7	Other (specify):*										7
8	TOTAL General Services	399,579	50,985	1,599,173	2,049,737	50	2,049,787	(1,541,263)	508,524		8
	B. Health Care and Programs										
9	Medical Director			31,800	31,800		31,800	(17,190)	14,610		9
10	Nursing and Medical Records	1,429,754	48,343	14,724	1,492,821		1,492,821	(538,715)	954,106		10
10a	Therapy										10a
11	Activities	128,566	7,963	6,395	142,924		142,924	(92,621)	50,303		11
12	Social Services	59,794		3,151	62,945	(200)	62,745	(23,188)	39,557		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,618,114	56,306	56,070	1,730,490	(200)	1,730,290	(671,714)	1,058,576		16
	C. General Administration										
17	Administrative	134,701			134,701		134,701	(79,503)	55,198		17
18	Directors Fees										18
19	Professional Services			570,030	570,030	(18,342)	551,688	(327,667)	224,021		19
20	Dues, Fees, Subscriptions & Promotions			153,607	153,607	(42,666)	110,941	(75,276)	35,665		20
21	Clerical & General Office Expenses	134,612	25,591	35,406	195,609		195,609	(115,945)	79,664		21
22	Employee Benefits & Payroll Taxes			642,727	642,727		642,727	(189,727)	453,000		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,694	5,694	18,092	23,786	(14,320)	9,466		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,616	64,616		64,616	(38,138)	26,478		26
27	Other (specify):*			36,607	36,607		36,607	(36,607)			27
28	TOTAL General Administration	269,313	25,591	1,508,687	1,803,591	(42,916)	1,760,675	(877,183)	883,492		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,287,006	132,882	3,163,930	5,583,818	(43,066)	5,540,752	(3,090,160)	2,450,592		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

Mercy Circle

#0051201

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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			1,106,567	1,106,567		1,106,567	(876,814)	229,753			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,288,837	1,288,837		1,288,837	(1,071,928)	216,909			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			120,000	120,000		120,000	(120,000)				34
35	Rent-Equipment & Vehicles			5,383	5,383		5,383	(4,534)	849			35
36	Other (specify):*											36
37	TOTAL Ownership			2,520,787	2,520,787		2,520,787	(2,073,276)	447,511			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			534,785	534,785		534,785	1,456	536,241			39
40	Barber and Beauty Shops			31,967	31,967		31,967		31,967			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					43,066	43,066		43,066			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			566,752	566,752	43,066	609,818	1,456	611,274			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,287,006	132,882	6,251,469	8,671,357		8,671,357	(5,161,980)	3,509,377			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	(29,284)	1		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	(929)	20		18
19	Entertainment				19
20	Contributions	(10)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,597)	27		24
25	Fund Raising, Advertising and Promotional	(19,565)	20		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)	\$ (86,385)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (86,385)		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

Mercy Circle

ID# 0051201

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Garage/Parking Fees	\$ (11,893)	6	1
2	Miscellaneous Revenue	(656)	21	2
3	Nursing Supplies/Briefs for AL/IL/Memory Care	(5,229)	10	3
4	Freight/Forms for AL/IL/Memory Care	(547)	21	4
5	Nursing Wages for AL/IL/Memory Care	(533,486)	10	5
6	Activity Wages for AL/IL/Memory Care	(81)	11	6
7	Recruitment/Fees for AL/IL/ Memory Care	(3,261)	20	7
8	Benefits for AL/IL/Memory Care	(37,784)	22	8
9	Linen for AL/IL/Memory Care	(1,316)	4	9
10	Physician Fees for AL/IL/Memory Care	(17,190)	9	10
11	Medical Supplies for AL/IL/Memory Care	1,456	39	11
12	Equipment Lease for AL/IL/Memory Care	(341)	35	12
13	Late Fee - Bed Tax	(152)	20	13
14	Public Relations expense	(5,000)	19	14
15	Training/Seminars for AL/IL/Memory Care	(685)	24	15
16	Remove Dietary Expense allocated to AL/IL	(823,732)	1	16
17	Remove Housekeeping Expense allocated to AL/IL	(127,023)	3	17
18	Remove Laundry Expense allocated to AL	(26,833)	4	18
19	Remove Utilities allocated to AL/IL	(136,854)	5	19
20	Remove Maintenance Costs allocated to AL/IL	(384,328)	6	20
21	Remove Activities allocated to AL	(92,540)	11	21
22	Remove Social Services allocated to AL/IL	(23,188)	12	22
23	Remove Admin Costs allocated to AL/IL	(79,503)	17	23
24	Remove Prof Svcs allocated to AL/IL	(322,667)	19	24
25	Remove Miscellaneous Exp allocated to AL/IL	(51,369)	20	25
26	Remove Gen office exp allocated to AL/IL	(114,742)	21	26
27	Remove Travel/Seminar exp allocated to AL/IL	(13,635)	24	27
28	Remove Insurance exp allocatd to AL/IL	(38,138)	26	28
29	Remove Depreciation exp allocated to AL/IL	(876,814)	30	29
30	Remove Interest exp allocated to AL/IL	(1,071,928)	32	30
31	Remove Lease exp allocated to AL/IL	(4,193)	35	31
32	Remove Benefits allocated to AL/IL	(151,943)	22	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	(4,955,595)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Circle# 0051201

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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

	Operating Expenses	PAGES	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	(853,016)	0	0	0	0	0	0	0	0	0	0	(853,016)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(127,023)	0	0	0	0	0	0	0	0	0	0	(127,023)	3
4	Laundry	(28,149)	0	0	0	0	0	0	0	0	0	0	(28,149)	4
5	Heat and Other Utilities	(136,854)	0	0	0	0	0	0	0	0	0	0	(136,854)	5
6	Maintenance	(396,221)	0	0	0	0	0	0	0	0	0	0	(396,221)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,541,263)	0	(1,541,263)	8									
	B. Health Care and Programs													
9	Medical Director	(17,190)	0	0	0	0	0	0	0	0	0	0	(17,190)	9
10	Nursing and Medical Records	(538,715)	0	0	0	0	0	0	0	0	0	0	(538,715)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(92,621)	0	0	0	0	0	0	0	0	0	0	(92,621)	11
12	Social Services	(23,188)	0	0	0	0	0	0	0	0	0	0	(23,188)	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	(671,714)	0	(671,714)	16									
	C. General Administration													
17	Administrative	(79,503)	0	0	0	0	0	0	0	0	0	0	(79,503)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(327,667)	0	0	0	0	0	0	0	0	0	0	(327,667)	19
20	Fees, Subscriptions & Promotions	(75,276)	0	0	0	0	0	0	0	0	0	0	(75,276)	20
21	Clerical & General Office Expenses	(115,945)	0	0	0	0	0	0	0	0	0	0	(115,945)	21
22	Employee Benefits & Payroll Taxes	(189,727)	0	0	0	0	0	0	0	0	0	0	(189,727)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(14,320)	0	0	0	0	0	0	0	0	0	0	(14,320)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(38,138)	0	0	0	0	0	0	0	0	0	0	(38,138)	26
27	Other (specify):*	(36,607)	0	0	0	0	0	0	0	0	0	0	(36,607)	27
28	TOTAL General Administration	(877,183)	0	(877,183)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,090,160)	0	(3,090,160)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mercy Circle# 0051201

Report Period Beginning:

07/01/2015 Ending:06/30/2016

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(876,814)	0	0	0	0	0	0	0	0	0	0	(876,814)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,071,928)	0	0	0	0	0	0	0	0	0	0	(1,071,928)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(120,000)	0	0	0	0	0	0	0	0	0	(120,000)	34
35	Rent-Equipment & Vehicles	(4,534)	0	0	0	0	0	0	0	0	0	0	(4,534)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,953,276)	(120,000)	0	(2,073,276)	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	1,456	0	0	0	0	0	0	0	0	0	0	1,456	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	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	1,456	0	0	0	0	0	0	0	0	0	0	1,456	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(5,041,980)	(120,000)	0	(5,161,980)	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
Sisters of Mercy of the Americas	100%	Catherine's Place	Farmington Hills, MI			
West Midwest Community, Inc.						
Laura Reicks, RSM	BOD					
Michael Davis	BOD					
LuAnn Hannasch, RSM	BOD					
John Eber	BOD					
Margaret Mary Hinz, RSM	BOD					

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 Land Lease	\$ 120,000	Sisters of Mercy of the Americas West Midwest Comm., Inc.	100.00%	\$	\$	(120,000) 1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 120,000			\$	\$ *	(120,000) 14

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

Facility Name & ID Number

Mercy Circle

0051201

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	Judith Miemet, RSM	BOD						1
2	Rhona Greensphan	BOD						2
3	Charles Stevenson	BOD						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 Mercy Circle # 0051201 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Mercy Circle

0051201

Report Period Beginning:

07/01/2015

Ending: 6/30/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number Mercy Circle

0051201

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	First National Bank		X	Construction of Facility	\$117,001.28		\$ 26,250,000	\$ 24,337,631		0.0340	\$ 1,258,958	1								
2	West Midwest FIDES	X					15,814,000	13,159,649		0.0325		2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$117,001.28		\$ 42,064,000	\$ 37,497,280			\$ 1,258,958	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 42,064,000	\$ 37,497,280			\$ 1,258,958	15								

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 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 2016 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:

2011	_____	8
2012	_____	9
2013	_____	10
2014	_____	11
2015	_____	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	\$ _____	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mercy Circle COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051201

CONTACT PERSON REGARDING THIS REPORT Pamela Latovick

TELEPHONE (734) 343-6628 FAX #: (734) 343-6461

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Mercy Circle

0051201

Report Period Beginning:

07/01/2015 Ending:

06/30/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,236 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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).

Mercy Circle, Assisted Living/Memory Care, 53,692 sq ft., 34 AL/9 MC units

Mercy Circle, Independent Living, 66078 sq ft., 44 units

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Mercy Circle

0051201

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	22			2014	\$ 6,537,662	\$ 163,442	40	\$ 163,442	\$	\$ 435,844
5										
6										
7										
8										
	Improvement Type**									
9	Aluminum Logo Sign		2015		631	63	10	63		121
10										
11										
12										
13										
14										
15										
16										
17										
18										
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)	\$ 6,538,293	\$ 163,505		\$ 163,505	\$	\$ 435,965	70

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

Facility Name & ID Number Mercy Circle

0051201

Report Period Beginning:

07/01/2015

Ending:

06/30/2016

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	\$ 349,156	\$ 39,044	\$ 39,044	\$	5/10	\$ 99,475	71
72	Current Year Purchases	10,338	238	238		5/7	238	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 359,494	\$ 39,282	\$ 39,282	\$		\$ 99,713	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	14 Passenger Van-Res Trans	Passenger Bus, 2013	2014	\$ 55,317	\$ 13,829	\$ 13,829	\$	4	\$ 36,878	76
77	Utility Truck - Maintenance	Dodge Ram Truck, 2013	2014	26,033	6,508	6,508		4	17,355	77
78	Car - Resident Transport	Toyota Camry, 2010	2014	14,344	3,586	3,586		4	7,471	78
79	Car - Resident Transport	Toyota Avalon, 2007	2014	12,171	3,043	3,043		4	6,339	79
80	TOTALS			\$ 107,865	\$ 26,966	\$ 26,966	\$		\$ 68,043	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)	\$ 7,005,652	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 229,753	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 229,753	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)	\$ 603,721	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	Building, 2014	\$ 32,307,965	\$ 807,699	\$ 2,153,864	86
87	Aluminum Logo Sign, 2015	3,119	312	598	87
88	Equipment, Prior Years	623,675	68,751	182,468	88
89	Equipment, Current Years	625	52	52	89
90					90
91	TOTALS	\$ 32,935,384	\$ 876,814	\$ 2,336,982	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 Mercy Circle

0051201

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 6,085 Description: Copier, Graphic Equipment, Postage Meter

(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	39-3	hrs	\$		\$ 193,604	\$ 132		\$ 193,736	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			74,179			74,179	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			179,247	3,095		182,342	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts			29,397			29,397	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Med Splies/Beds/Oxyge</u>	39-3				50,258			50,258	12
13	Other (specify): <u>Lab/X-Ray</u>	39-3				4,873			4,873	13
14	TOTAL			\$		\$ 531,558	\$ 3,227		\$ 534,785	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/2016**

(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	\$ 501,107	\$	1
2	Cash-Patient Deposits	25,031		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (12000))	355,337		3
4	Supply Inventory (priced at)	30,431		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,118		6
7	Other Prepaid Expenses	4,907		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 923,931	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	38,849,377		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,091,658		16
17	Accumulated Depreciation (book methods)	(2,940,704)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,176,369		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(140,677)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: Land Lease)	1,849,246		22
23	Other(specify): Construction in Progress	707		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 40,885,976	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 41,809,907	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,035,005	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,523		28
29	Short-Term Notes Payable	554,284		29
30	Accrued Salaries Payable	155,210		30
31	Accrued Taxes Payable (excluding real estate taxes)	(290)		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,776,732	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	13,159,649		40
41	Bonds Payable	24,337,631		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Restricted Assets/Donations	1,422,337		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 38,919,617	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 43,696,349	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,886,442)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 41,809,907	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,679,040)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,679,040)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,886,442)	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) Change in unrestricted net assets	2,679,040	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 792,598	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)	\$ (1,886,442)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mercy Circle

0051201

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,729,697	1
2	Discounts and Allowances for all Levels	(335,884)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,393,813	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	421,940	6
7	Oxygen	446	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 422,386	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	32,081	13
14	Non-Patient Meals	29,284	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	11,893	16
17	Sale of Drugs	3,216	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,557	20
21	Other Medical Services	23,010	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 104,041	23
D. Non-Operating Revenue			
24	Contributions	864,256	24
25	Interest and Other Investment Income***	2	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 864,258	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Short Term Capital Gain</u>	417	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 417	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,784,915	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,049,737	31
32	Health Care	1,730,490	32
33	General Administration	1,803,591	33
B. Capital Expense			
34	Ownership	2,520,787	34
C. Ancillary Expense			
35	Special Cost Centers	566,752	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,671,357	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,886,442)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,886,442)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 708,263	44
45	Private Pay - Net Inpatient Revenue	257,220	45
46	Medicare - Net Inpatient Revenue	606,657	46
47	Other-(specify) <u>Hospice</u>	763	47
48	Other-(specify) <u>Assisted/Independent Living</u>	3,820,910	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,393,813	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Mercy Circle

0051201

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

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	1,840	2,096	\$ 90,171	\$ 43.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,746	14,050	464,224	33.04	3
4	Licensed Practical Nurses	7,576	8,534	202,658	23.75	4
5	CNAs & Orderlies	39,875	44,147	643,358	14.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,413	1,547	49,279	31.85	9
10	Activity Assistants	5,415	5,731	79,287	13.83	10
11	Social Service Workers	1,702	1,821	59,794	32.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	10,226	11,535	251,655	21.82	17
18	Housekeepers	8,555	9,768	147,924	15.14	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	3,621	4,351	105,321	24.21	22
23	Office Manager	1,908	2,096	55,787	26.62	23
24	Clerical	5,952	6,647	108,205	16.28	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	1,815	2,083	29,343	14.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	102,644	114,406	\$ 2,287,006 *	\$ 19.99	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director			36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant			39	
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant	35	1,902	11/3	44
45	Social Service Consultant	47	2,888	12/3	45
46	Other(specify)				46
47	Security	3,537	70,429	6/3	47
48					48
49	TOTAL (lines 35 - 48)	3,619	\$ 75,219		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		
Diana Bowden	Office Manager	0	\$ 49,593	Workers' Compensation Insurance	\$ 44,419	IDPH License Fee	\$ 3,980		
Patricia Campbell	Exec Assistant	0	39,683	Unemployment Compensation Insurance	21,663	Advertising: Employee Recruitment	8,634		
Patricia Kouba	HR Coordinator	0	45,425	FICA Taxes	124,719	Health Care Worker Background Check	400		
				Employee Health Insurance	348,643	(Indicate # of checks performed <u> 15 </u>)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions/Ref Material	3,420		
				Employee Life Insurance	24,728	Licenses & Taxes	3,663		
				403B Employer Match	34,789	Bank/Trust Acct./Letter of Credit Fees	66,937		
				Employee Appreciation	5,933	Dues/Fees allocated to AL/IL	(51,369)		
				Employee Assistance Program	49				
				Expense allocated to AL/IL	(151,943)	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 134,701	TOTAL (agree to Schedule V, line 22, col.8)		\$ 453,000	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 35,665
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							Trinity Senior Living Comm. Travel	18,142	
							First Nat'l Bank - Travel to MI/NE	1,206	
							In-State Travel		
							Misc Travel to pick up Supplies	519	
							Trave/Sem Exp allocated to AL/IL	(13,635)	
							Seminar Expense		
							Activities Training/Seminar	740	
							Admin - Conferences	2,228	
							Trinity Senior Living Comm. Meetings	266	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 9,466	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
Shirley Masters	consult on billing software		\$ 1,225						
Trinity Senior Living Comm.	mgt fees/travel exp/consult		318,534						
Westshore Counsel, LLC	Igl svcs - OCR request		2,325						
Corporation Service Company	Igl svcs - statutory represent.		104						
Plante & Moran, PLLC	Financial Statement review		18,500						
Trinity Senior Living Comm.	Adm Sal/Benefits		146,594						
Sisters of Mercy - Americas	Telephone - Access One/ATT		12,714						
Sisters of Mercy - Americas	EHR - Wescom Solutions		12,797						
Sisters of Mercy - Americas	Retire Plan - Christian Bros		3,162						
Access Media 3	Direct TV		43,386						
Pointright	Clinical Software		2,500						
Shred it/First Nat'l Bank, Various	Misc. Expense - see detail		8,189						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 570,030						
(For legal fee disclosure, see page 39 of instructions)									

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mercy Circle# 0051201Report Period Beginning: 07/01/2015Ending: 06/30/2016**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. Leading Age of Illinois \$425.00
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Y
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,329 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 30,988
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? Yes 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 29,284
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0
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? Yes
g. **Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (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

Mercy Circle
Professional Services
FYE 6-30-15

Trinity Sr. Living Communities	300,000	Management Fee
	18,142	Travel to Mercy Circle to be reclassified to Travel
	392	Masters/Press Ganey consulting
Shirley Masters	1,225	Consulting on Billing Software
	2,500	Pointright - Clinical Software
Plante and Moran	18,500	Accounting Services
Illinois State Police	200	Replen Background Checks act r/c to Dues/Fees
Trinity Sr. Living Communities	146,594	Administrator salary and benefits
Access Media 3, Inc.	43,386	HD Direct TV Programming
Sheila King	5,000	Public Relations Services - to be removed
ATT / Access One, Inc.	12,714	Telephone Service
Wescom Solutions	12,797	EMR - Point Click Care
Secretary of State	10	Annual Report Filing
Christian Brothers Services	3,162	Retirement Planning quarterly fee
Hillside Signs	197	Badges with Logo
First Nat'l Bank Omaha	50	Misc.
Shred-It USA LLC	1,947	Shredding Services
Advanced Telecommunications	284	Repair of Shoretel BB24
MHA Service Corp/Lansing	500	Unemploy Comp Adm charge
Westshore Counsel, LLC	2,325	OCR request response, CON work
Corporation Service Comp.	104	Statutory Representative
Total	570,030	

Dues, Fees, Subscriptions

		Est	
		# Checks	
Background Checks			
IL State Police	200	3/23/2016	3 Reclass from Prof Svcs
IL State Police	200	9/10/2015	12 Reclass from Social Services
	400		15
Adv./Empl Recruit	8,634		
Dues & Subscriptions	3,101		
IDPH License Fee	3,980		
Licenses & Fees	3,663		
Bank/Trust Act/LOC	66,937		
Ref Materials	319		
	87,034		

Leased Equipment

Cannon Finan Svcs	4,542	Graphic Equipment
Martin Whalen Office	489	Copier
Pitney Bowes Global	351	Postage Meter
Pitney Bowes Global	702	Reclass from Office Supplies, Line 21
	6,085	

Employee Benefits

Employee Benefits/Payroll Taxes	Col. 3	Col. 7	Adjusted
Workers Compensation	44,419		44,419
Unemployment Comp.	21,663		21,663
FICA Taxes	162,503	(37,784)	124,719
Employee Health Insurance	348,642		348,642
Employee Life Insurance	24,728		24,728
Employee Pension			-
403B Employer Match	34,789		34,789
Employee Appreciation	5,982		5,982
	642,727	(37,784)	604,943

Travel

First Nat'l Bank Omaha	527	Admin	Flight to Detroit, Flight to Omaha
First Nat'l Bank Omaha	543	Admin	Flights to Omaha
First Nat'l Bank Omaha	137	N Admin	Transportation in Detroit
Rest Transportation	47	N Admin	Local Transportation
Payroll	471	Social Svc	Reimb for local travel
First Nat'l Bank Omaha	1	Maintenan	Parking Meter
First Nat'l Bank Omaha	50	Maintenan	Bremens Service - Drain issue, r/c to Maintenance
TSLC - out of State	-	Admin	Travel of TSLC employees to Mercy Circle
Total Travel	1,775		

Training/Seminars

Mercy Network on Aging	750	Admin	Conference, 2 people
First Nat'l Bank Omaha	135	Admin	Life Services Network conference
First Nat'l Bank Omaha	620	Admin	Life Services Network conference, 2 people
Trinity Senior Living Comm.	266	Admin	Meetings on Clin/Ops Consults
First Nat'l Bank Omaha	99	Admin	Culture Change Webinar
First Nat'l Bank Omaha	624	Admin	Life Svcs Network Webinar/Leading Age Conf.
Petty Cash	30	Activities	
First Nat'l Bank Omaha	220	Activities	Chair Chi Training
First Nat'l Bank Omaha	450	Activities	Quality Therapy Cons. - seminar
Northern Illinois Activit	40	Activities	Training - Making a Difference in ST Rehat
	3,234		

Mercy Circle
 Consultants
 FYE 6-30-16

Date	Hours	\$
Social Services		
7/31/2015 Socialwork Consultation (10	620
8/31/2015	12.5	775
9/30/2015	8.5	527
10/31/2015	5.5	341
12/31/2015	5	310
1/31/2016	5	315
	46.5	2888
Activities		
11/17/2015 Socialwork Consultation (8.5	263.5
2/29/2016	14.5	913.5
3/31/2016	5.5	346.5
4/30/2016	6	378
	34.5	1901.5

Maintenance		
Date	Hours	\$
6/29/2015 Excel Security Services, I	38.75	1395
7/15/2015	84	1302
7/20/2015	89.5	1386
7/27/2015	88	1364
8/3/2015	92	1426
8/10/2015	104	1612
8/17/2015	88	1364
8/24/2015	15.5	1302
9/1/2015	15.5	1302
9/7/2015	15.5	1302
9/14/2015	84	1395
9/23/2015	15.5	1302
9/28/2015	15.5	1302
10/5/2015	15.5	1302
10/12/2015	15.5	1302
10/19/2015	15.5	1302
10/29/2015	15.5	1302
11/2/2015	15.5	1302
11/12/2015	15.5	1302
11/16/2015	15.5	1302
11/23/2015	87	1348.5
11/30/2015	84	1488
12/7/2015	15.5	1550
12/14/2015	84	1302
12/21/2015	96	1488
12/21/2015	90	1534.5
1/4/2016	90	1488
1/11/2016	94	1457
1/18/2016	84	1302
1/25/2016	84	1302
2/1/2016	84	1302
2/8/2016	84	1302
2/15/2016	84	1302
2/22/2016	84	1302
2/29/2016	84	1302
3/7/2016	84	1302
3/15/2016	84	1302
3/21/2016	84	1302
3/28/2016	84	1395
4/4/2016	84	1302
4/11/2016	88	1364
4/18/2016	84	1302
4/25/2016	84	1302
5/2/2016	84	1302
5/9/2016	94	1457
5/16/2016	84	1302
5/23/2016	84	1302
5/30/2016	88	1364
6/6/2016	84	1302
6/13/2016	88	1418.56
6/20/2016	84	1354.08
6/27/2016	88	1418.56
	3536.75	70429.2

Mercy Circle
Adjustments to Expense
FYE 6-30-16

Direct Expense for AL/IL and MC		
Description	Amount	Line #
Supplies/Briefs	(5,229)	10
Forms/Misc	(547)	21
Nursing Wages	(533,486)	10
Activities Wages	(81)	11
Recruit/Fees	(3,261)	20
Benefits	(37,784)	22
Training/Seminars	(685)	24
Linen	(1,316)	4
Physician Fees	(17,190)	9
Medical Supplies	1,456	39
Equip Lease	(341)	35
Total	(598,465)	

Allocate Indirect Expense to AL/IL

Line #	1	3	4	5	6	11	12	17	19	20	21	24	26	30	32	35	Total
Cost Center	Dietary	Housekpg	Laundry	Utilities	Maintenance	Activities	Soc. Svcs.	Admin	Prof Svcs	Misc.	Gen Office	Trav/Sem	Insurance	Depreciation	Interest	Rent Equip	
Direct Expense	1,141,146	172,296	41,419	171,318	481,115	142,843	62,745	134,701	546,688	87,034	194,406	23,101	64,616	1,106,567	1,288,837	5,042	5,663,874
Benefits	-	39,128	-	-	66,566	34,007	15,816	35,630	-	-	35,607	-	-	-	-	-	226,754
Total Expense to Alloc	1,141,146	211,424	41,419	171,318	547,681	176,850	78,561	170,331	546,688	87,034	230,013	23,101	64,616	1,106,567	1,288,837	5,042	5,890,628

Direct Expense

AL	583,922	56,339	26,833	42,889	120,444	92,540	12,276	54,362	220,628	35,125	78,457	9,323	26,077	-	-	-	1,359,214
IL	239,810	70,685	-	93,965	263,884	-	10,912	25,142	102,038	16,245	36,286	4,312	12,060	876,814	1,071,928	4,193	2,828,273
SNF	317,414	45,273	14,586	34,464	96,787	50,303	39,557	55,198	224,021	35,665	79,664	9,466	26,478	229,753	216,909	849	1,476,387
Total	1,141,146	172,296	41,419	171,318	481,115	142,843	62,745	134,701	546,688	87,034	194,406	23,101	64,616	1,106,567	1,288,837	5,042	5,663,874

Benefits

AL		12,794			16,664	22,031	3,094	14,379			14,370						83,334
IL		16,052			36,510	-	2,751	6,650			6,646						68,610
SNF		10,281			13,391	11,976	9,971	14,601			14,591						74,811
Total		39,128			66,566	34,007	15,816	35,630			35,607						226,754

Statistic	Meals	Adj Sq Ftge	Patient Days	Sq Footage	Sq Footage	Patient Days	Discharges	Accum Cost	Depr Exp	Bldg Cost					
AL	36,546	30,160	12,182	30,160	30,160	12,182	9	1,588,292	1,588,292	1,588,292	1,588,292	1,588,292	1,588,292		
IL	15,009	37,840	-	66,078	66,078	-	8	734,569	734,569	734,569	734,569	734,569	734,569	876,814	32,307,965
SNF	19,866	24,236	6,622	24,236	24,236	6,622	29	1,612,719	1,612,719	1,612,719	1,612,719	1,612,719	1,612,719	229,753	6,537,662
Total	71,421	92,236	18,804	120,474	120,474	18,804	46	3,935,581	3,935,581	3,935,581	3,935,581	3,935,581	3,935,581	1,106,567	38,845,627

Notes:

AL/MC receive 3 meals/day, IL receives 1 meal/day.
 IL receives housekeeping biweekly, square footage adjusted to reflect IL common areas + 2/7 apartment areas.
 IL does their own laundry.
 IL can attend Activities offered in the community but the Activities program is geared to the SNF, AL and MC.
 Depreciation for AL/MC and IL combined for purposes of allocation.
 Interest for AL/MC and IL combined for purposes of allocation.

Adjustments to Expense
 FYE 6-30-16

<u>Description</u>	<u>Amount</u>	<u>Line #</u>	
Meal Income	(29,284)	1	Revenue Offsets Administrative/LTC only
Garage/Parking Fees	(11,893)	6	
Miscellaneous Revenue	(656)	21	
Gain/Loss on Sale of Equip	N/A	30	
Bad Debt Expense	(36,597)	27	F/S Expense Offsets
Contributions	(10)	27	
Marketing Expense	(19,565)	20	
Fines & Penalties	(929)	20	
Late Fee - Bed Tax	(152)	20	
PR Expense	(5,000)	19	
Provider Participation Fee	43,066	42	Reclasses of expense
	(43,066)	20	
Background Checks Fee	400	20	
	(200)	19	
	(200)	12	
TSLC Travel	18,142	24	
	(18,142)	19	
Maintenance Repair	50	6	
	(50)	24	

Mercy Circle
Fixed Asset Schedule - SNF
FYE 6/30

Year	Building	Cost	Disposals	Life	Annual Depr.	A/D 6/30/14	Depr 6/30/15	A/D 6/30/15	Depr 6-30-16	A/D 6/30/16
2014	Building - Initial Cost	6,537,662		40	163,442	108,961	163,442	272,403	163,442	435,844
2015	Aluminum Logo Sign	631		10	63	-	58	58	63	121
		6,538,294				108,961	163,499	272,460	163,505	435,965
Equipment										
2014	Initial Purchase IL/Commons	-		10	-	-	-	-	-	-
2014	Initial Purchase AL/SNF	299,801		10	29,980	19,987	29,980	49,967	29,980	79,947
2014	Staff Computers - opening	6,355		5	1,271	847	1,271	2,118	1,271	3,389
2014	Office Phones - Shoretel	783		5	157	104	157	261	157	418
2014	Plant Ops Smallwares	4,071		5	814	543	814	1,357	814	2,171
2014	Medical Equip Smallwares	23,962		5	4,792	399	4,792	5,192	4,792	9,984
2014	AL Televisions & Wall Mounts	-		5	-	-	-	-	-	-
2014	Kitchen Hood	276		5	55	37	55	92	55	147
		335,248					37,070	58,987	37,070	96,056
2015	Dynatronics - Rnd Ped Table	93		10	9		5.44	5	9	15
2015	Nativity Scene	192		10	19		11.17	11	19	30
2015	Multi Purp Rack & H/L Eco-Line	985		10	99		49.26	49	99	148
2015	Evaporator Fan Motor	130		10	13		3.24	3	13	16
2015	Eco Mat Table	64		5	13		9.57	10	13	22
2015	Combo-Stim Ultrasound	3,295		5	659		494.25	494	659	1,153
2015	Recurrent Stepper	3,795		15	253		189.75	190	253	443
2015	Upper Body Exerciser	3,455		5	691		518.25	518	691	1,209
2015	Parallel Bars	765		10	77		57.38	57	77	134
2015	Treadmill	1,135		8	142		106.40	106	142	248
FY2015		13,908					1,445	1,445	1,974	3,419
2016	Samsung TV	126		5	25				11	11
2016	Oxygen Concentrator Machine	2,024		7	289				72	72
2016	Oxygen Concentrator Machine	2,284		7	326				82	82
2016	Dell Optiplex 3240	798		5	160				13	13
2016	Simplex Nurse Call System	5,105		7	729				61	61
FY2016		10,338							238	238
Vehicles										
2007	Toyota Avalon	12,171		4	3,043	254	3,043	3,296	3,043	6,339
2006	Ford 500SE	6,957	(6,957)	4	1,739		(1,052)	-	-	-
2010	Toyota Camry	14,344		4	3,586	299	3,586	3,885	3,586	7,471
2013	14 Passenger Bus	55,317		4	13,829	9,219	13,829	23,049	13,829	36,878
2013	Dodge Ram Truck	26,033		4	6,508	4,339	6,508	10,847	6,508	17,355
		114,822	(6,957)			14,111	25,915	41,077	26,966	68,043
Bldg	6,538,294					108,961	163,499	272,460	163,505	435,965
Equip/Vehicles	467,359					14,111	64,429	101,509	66,248	167,757

	IL	AL	MC	SNF	Total
Rooms	39,533	17,019	2,959	3,982	63,493
Common Areas	26,545	13,141	20,573	20,254	80,513
Total	66,078	30,160	23,532	24,236	144,006

% SNF 16.83%
% SNF/(AL/SNF) 50.74%

Mercy Circle
 Fixed Asset Schedule - IL/AL/MC
 FYE 6/30

Year	Building	Cost	Disposals	Life	Annual Depr.	A/D 6/30/14	Depr 6/30/15	A/D 6/30/15	Depr 6-30-16	
2014	Building - Initial Cost	32,307,965		40	807,699	538,466	807,699	1,346,165	807,699	2,153,864
2015	Aluminum Logo Sign	3,119		10	312	-	286	286	312	598
		<u>32,311,084</u>				<u>538,466</u>	<u>807,985</u>	<u>1,346,451</u>	<u>808,011</u>	<u>2,154,462</u>
Equipment										
2014	Initial Purchase IL/Commons	261,826		10	26,183	17,455	26,183	43,638	26,183	69,820
2014	Initial Purchase AL/SNF	291,093		10	29,109	19,406	29,109	48,515	29,109	77,625
2014	Staff Computers - opening	31,406		5	6,281	4,187	6,281	10,469	6,281	16,750
2014	Office Phones - Shoretel	3,870		5	774	516	774	1,290	774	2,064
2014	Plant Ops Smallwares	20,118		5	4,024	2,682	4,024	6,706	4,024	10,730
2014	Medical Equip Smallwares	-		5	-	-	-	-	-	-
2014	AL Televisions & Wall Mounts	6,768		5	1,354	902	1,354	2,256	1,354	3,610
2014	Kitchen Hood	1,362		5	272	182	272	454	272	726
		<u>616,443</u>					<u>67,997</u>	<u>113,328</u>	<u>67,997</u>	<u>181,325</u>
2015	Dynatronics - Rnd Ped Table	461		10	46	-	26.88	27	46	73
2015	Nativity Scene	946		10	95	-	55.21	55	95	150
2015	Multi Purp Rack & H/L Eco-Line	4,869		10	487	-	243.44	243	487	730
2015	Evaporator Fan Motor	640		10	64	-	16.01	16	64	80
2015	Eco Mat Table	315		5	63	-	47.28	47	63	110
2015	Combo-Stim Ultrasound	-		5	-	-	-	-	-	-
2015	Recumbent Stepper	-		15	-	-	-	-	-	-
2015	Upper Body Exerciser	-		5	-	-	-	-	-	-
2015	Parallel Bars	-		10	-	-	-	-	-	-
2015	Treadmill	-		8	-	-	-	-	-	-
	FY2015	<u>7,232</u>					<u>389</u>	<u>389</u>	<u>755</u>	<u>1,143</u>
2016	Samsung TV	625		5	125	-	-	-	52	52
2016	Oxygen Concentrator Machine	-		7	-	-	-	-	-	-
2016	Oxygen Concentrator Machine	-		7	-	-	-	-	-	-
2016	Dell Optiplex 3240	-		5	-	-	-	-	-	-
2016	Simplex Nurse Call System	-		7	-	-	-	-	-	-
	FY2016	<u>625</u>							<u>52</u>	<u>52</u>
Vehicles										
2007	Toyota Avalon	-		4	-	-	-	-	-	-
2006	Ford 500SE	-		4	-	-	-	-	-	-
2010	Toyota Camry	-		4	-	-	-	-	-	-
2013	14 Passenger Bus	-		4	-	-	-	-	-	-
2013	Dodge Ram Truck	-		4	-	-	-	-	-	-
		<u>-</u>					<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Bldg	32,311,084			538,466	807,985	1,346,451	808,011	2,154,462	
	Equip/Vehicles	624,299			-	68,386	113,717	68,803	182,520	