

Facility Name & ID Number Mercy Circle

0051201 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 06/28/17

	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>23</u>	<u>8,033</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>23</u>	<u>8,033</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>4,807</u>	<u>833</u>	<u>1,533</u>	<u>7,173</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>4,807</u>	<u>833</u>	<u>1,533</u>	<u>7,173</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.29%

D. How many bed reserve days during this year were paid by the Department?
6 (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 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 1,239

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: 07/01/2016 Ending: 06/30/2017

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		830	1,191,223	1,192,053	24,882	1,216,935	(890,095)	326,840		1
2	Food Purchase										2
3	Housekeeping	156,913	21,811		178,724		178,724	(131,762)	46,962		3
4	Laundry			42,409	42,409		42,409	(27,705)	14,704		4
5	Heat and Other Utilities			219,112	219,112		219,112	(175,033)	44,079		5
6	Maintenance	243,917	27,836	226,268	498,021	5,447	503,468	(404,801)	98,667		6
7	Other (specify):*										7
8	TOTAL General Services	400,830	50,477	1,679,012	2,130,319	30,329	2,160,648	(1,629,396)	531,252		8
	B. Health Care and Programs										
9	Medical Director			33,000	33,000		33,000	(6,360)	26,640		9
10	Nursing and Medical Records	1,473,231	54,108	12,939	1,540,278	(219)	1,540,059	(626,560)	913,499		10
10a	Therapy										10a
11	Activities	162,476	4,851	7,498	174,825	1,042	175,867	(114,956)	60,911		11
12	Social Services	66,555		727	67,282	(200)	67,082	(18,192)	48,890		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,702,262	58,959	54,164	1,815,385	623	1,816,008	(766,068)	1,049,940		16
	C. General Administration										
17	Administrative	101,684			101,684		101,684	(61,590)	40,094		17
18	Directors Fees										18
19	Professional Services			685,561	685,561	(44,908)	640,653	(388,042)	252,611		19
20	Dues, Fees, Subscriptions & Promotions			245,528	245,528	(45,449)	200,079	(164,933)	35,146		20
21	Clerical & General Office Expenses	203,867	29,510	63,266	296,643	168	296,811	(180,656)	116,155		21
22	Employee Benefits & Payroll Taxes			676,246	676,246		676,246	(214,245)	462,001		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,040	5,040	19,107	24,147	(14,661)	9,486		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			63,229	63,229		63,229	(38,298)	24,931		26
27	Other (specify):* Bad Debt/Contrib.			68,545	68,545		68,545	(68,545)			27
28	TOTAL General Administration	305,551	29,510	1,807,415	2,142,476	(71,082)	2,071,394	(1,130,970)	940,424		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,408,643	138,946	3,540,591	6,088,180	(40,130)	6,048,050	(3,526,434)	2,521,616		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:

07/01/2016

Ending:

06/30/2017

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			1,109,064	1,109,064		1,109,064	(877,193)	231,871			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,268,041	1,268,041		1,268,041	(1,045,442)	222,599			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			120,000	120,000		120,000	(120,000)				34
35	Rent-Equipment & Vehicles			12,165	12,165	(5,519)	6,646	(5,506)	1,140			35
36	Other (specify):*											36
37	TOTAL Ownership			2,509,270	2,509,270	(5,519)	2,503,751	(2,048,141)	455,610			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			507,019	507,019		507,019	(150)	506,869			39
40	Barber and Beauty Shops			30,445	30,445		30,445		30,445			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					45,649	45,649		45,649			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			537,464	537,464	45,649	583,113	(150)	582,963			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,408,643	138,946	6,587,325	9,134,914		9,134,914	(5,574,725)	3,560,189			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	(35,215)	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	(90)	32		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	(120)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,545)	27		24
25	Fund Raising, Advertising and Promotional	(113,696)	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)	\$ (217,666)		\$	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))	\$ (217,666)		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: 07/01/2016

Ending: 06/30/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Garage Parking Fees	\$ (12,000)	6	1
2	Miscellaneous Revenue	(2,122)	21	2
3	Nursing Supplies/Briefs for AL/IL/Memory Care	(4,964)	10	3
4	Freight/Forms for AL/IL/Memory Care	(9)	21	4
5	Nursing Wages for AL/IL/Memory Care	(621,596)	10	5
6	Activity Wages for AL/IL/Memory Care	(190)	11	6
7	Recruitment/Fees for AL/IL/Memory Care	(250)	20	7
8	Benefits for AL/IL/Memory Care	(46,928)	22	8
9	Physician Fees for AL/IL/Memory Care	(6,360)	9	9
10	Medical Supplies for AL/IL/Memory Care	(150)	39	10
11	Training/Seminars for AL/IL/Memory Care	(89)	24	11
12	Maintenance for AL/IL/Memory Care	(81)	6	12
13	Late Fee - Bed Tax	(152)	20	13
14	Late Fee - Copier	(151)	35	14
15	Pr.Period Income Tax Refund	3,274	20	15
16	Miscellaneous - Postage, Jury Duty, Telephone	(97)	21	16
17	Miscellaneous - Catering Income	(697)	1	17
18	Miscellaneous - Maintenance	(925)	6	18
19	Miscellaneous - Benefits	(7,245)	22	19
20	Remove Dietary Expense allocated to AL/IL	(854,183)	1	20
21	Remove Housekeeping Expense allocated to AL/IL	(131,762)	3	21
22	Remove Laundry Expense allocated to AL/IL	(27,705)	4	22
23	Remove Utilities allocated to AL/IL	(175,033)	5	23
24	Remove Maintenance Expense allocated to AL/IL	(391,795)	6	24
25	Remove Activy Expense allocated to AL/IL	(114,766)	11	25
26	Remove Social Services Expense allocated to AL/IL	(18,192)	12	26
27	Remove Admin Expense allocated to AL/IL	(61,590)	17	27
28	Remove Professional Services allocated to AL/IL	(388,042)	19	28
29	Remove Miscellaneous Expense allocated to AL/IL	(53,989)	20	29
30	Remove Gen Office Expenses allocated to AL/IL	(178,428)	21	30
31	Remove Travel/Seminar Expense allocated to AL/IL	(14,572)	24	31
32	Remove Insurance Expense allocated to AL/IL	(38,298)	26	32
33	Remove Depreciation Expense allocated to AL/IL	(877,193)	30	33
34	Remove Interest Expense allocated to AL/IL	(1,045,352)	32	34
35	Remove Rental Expense allocated to AL/IL	(5,355)	35	35
36	Remove Benefits allocated to AL/IL	(160,072)	22	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	(5,237,059)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Circle# 0051201

Report Period Beginning:

07/01/2016

Ending:

06/30/2017

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	(890,095)	0	0	0	0	0	0	0	0	0	0	(890,095)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(131,762)	0	0	0	0	0	0	0	0	0	0	(131,762)	3
4	Laundry	(27,705)	0	0	0	0	0	0	0	0	0	0	(27,705)	4
5	Heat and Other Utilities	(175,033)	0	0	0	0	0	0	0	0	0	0	(175,033)	5
6	Maintenance	(404,801)	0	0	0	0	0	0	0	0	0	0	(404,801)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,629,396)	0	(1,629,396)	8									
	B. Health Care and Programs													
9	Medical Director	(6,360)	0	0	0	0	0	0	0	0	0	0	(6,360)	9
10	Nursing and Medical Records	(626,560)	0	0	0	0	0	0	0	0	0	0	(626,560)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(114,956)	0	0	0	0	0	0	0	0	0	0	(114,956)	11
12	Social Services	(18,192)	0	0	0	0	0	0	0	0	0	0	(18,192)	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	(766,068)	0	(766,068)	16									
	C. General Administration													
17	Administrative	(61,590)	0	0	0	0	0	0	0	0	0	0	(61,590)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(388,042)	0	0	0	0	0	0	0	0	0	0	(388,042)	19
20	Fees, Subscriptions & Promotions	(164,933)	0	0	0	0	0	0	0	0	0	0	(164,933)	20
21	Clerical & General Office Expenses	(180,656)	0	0	0	0	0	0	0	0	0	0	(180,656)	21
22	Employee Benefits & Payroll Taxes	(214,245)	0	0	0	0	0	0	0	0	0	0	(214,245)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(14,661)	0	0	0	0	0	0	0	0	0	0	(14,661)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(38,298)	0	0	0	0	0	0	0	0	0	0	(38,298)	26
27	Other (specify):*	(68,545)	0	0	0	0	0	0	0	0	0	0	(68,545)	27
28	TOTAL General Administration	(1,130,970)	0	(1,130,970)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,526,434)	0	(3,526,434)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mercy Circle# 0051201

Report Period Beginning:

07/01/2016 Ending:06/30/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(877,193)	0	0	0	0	0	0	0	0	0	0	(877,193)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,045,442)	0	0	0	0	0	0	0	0	0	0	(1,045,442)	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	(5,506)	0	0	0	0	0	0	0	0	0	0	(5,506)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,928,141)	(120,000)	0	(2,048,141)	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	(150)	0	0	0	0	0	0	0	0	0	0	(150)	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	(150)	0	0	0	0	0	0	0	0	0	0	(150)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(5,454,725)	(120,000)	0	(5,574,725)	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					
John Eber	BOD					
Margaret Mary Hinz, RSM	BOD					
Judith Miemet, 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	19 Leadership wages/benefits	29,892	Sisters of Mercy of the Americas West Midwest Comm., Inc.	100.00%	29,892		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		\$ 149,892			\$ 29,892	\$ *	(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: 07/01/2016 Ending: 06/30/2017

VII. RELATED PARTIES (continued)

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

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

	1 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:

07/01/2016

Ending: 6/30/2017

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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:

07/01/2016

Ending:

06/30/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					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			\$ 26,250,000	\$ 19,197,754			0.0340	\$ 1,238,162					
2	West Midwest FIDES	X					15,814,000	13,208,852			0.0325						
3																	
4																	
5																	
Working Capital																	
6																	
7																	
8																	
9	TOTAL Facility Related						\$ 42,064,000	\$ 32,406,606				\$ 1,238,162					
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$				\$					
15	TOTALS (line 9+line14)						\$ 42,064,000	\$ 32,406,606				\$ 1,238,162					

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 2016 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2012	8	
	2013	9	
	2014	10	
	2015	11	
	2016	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2016 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

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

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Mercy Circle

0051201 Report Period Beginning:

07/01/2016 Ending:

06/30/2017

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, 66,078 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

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	\$	\$ 599,286	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Aluminum Logo Sign			2015	631	63	10	63		184	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

*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	\$	\$ 599,470	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:

07/01/2016

Ending:

06/30/2017

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 359,494	\$ 40,573	\$ 40,573	\$	5/7/2010	\$ 140,287	71
72	Current Year Purchases	8,675	826	826		5/10	826	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 368,169	\$ 41,399	\$ 41,399	\$		\$ 141,113	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	\$ 50,707	76
77	Utility Truck-Maintenance	Dodge Ram Truck, 2013	2014	26,033	6,508	6,508		4	23,863	77
78	Car - Resident Transport	Toyota Camry, 2010	2014	14,344	3,586	3,586		4	11,057	78
79	Car - Resident Transport	Toyota Avalon, 2007	2014	12,171	3,043	3,043		4	9,382	79
80	TOTALS			\$ 107,865	\$ 26,966	\$ 26,966	\$		\$ 95,009	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)	\$ 7,014,327	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 231,870	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 231,870	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)	\$ 835,592	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	\$ 2,961,563	86
87	Aluminum Logo Sign, 2015	3,119	312	910	87
88	Equipment, Prior Years	624,300	68,876	251,396	88
89	Equipment, Current Year	4,830	306	306	89
90					90
91	TOTALS	\$ 32,940,214	\$ 877,193	\$ 3,214,175	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: 07/01/2016

Ending: 06/30/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 6,495 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	\$		\$ 190,306	\$ 476		\$ 190,782	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			48,100	919		49,019	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			176,884	2,944		179,828	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescripts			47,474			47,474	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				34,379			34,379	12
13	Other (specify): <u>Lab/Xray</u>	39-3				5,537			5,537	13
14	TOTAL			\$		\$ 502,680	\$ 4,339		\$ 507,019	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 **06/30/2017**

(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	\$ 817,178	\$	1
2	Cash-Patient Deposits	22,021		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 58,880)	461,878		3
4	Supply Inventory (priced at)	38,389		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,339,466	\$	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	1,105,164		16
17	Accumulated Depreciation (book methods)	(4,049,768)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,176,369		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(199,287)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: Land Lease	1,821,078		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 39,702,933	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 41,042,399	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,703,837	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	109,703		28
29	Short-Term Notes Payable	554,284		29
30	Accrued Salaries Payable	155,767		30
31	Accrued Taxes Payable (excluding real estate taxes)	585		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)	\$ 5,524,176	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	13,208,852		40
41	Bonds Payable	18,643,470		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Restricted Assets/Donations	(481,180)		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 31,371,142	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 36,895,318	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 4,147,081	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 41,042,399	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,886,442)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,886,442)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,147,079	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	1,886,444	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 6,033,523	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)	\$ 4,147,081	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mercy Circle

0051201

Report Period Beginning: 07/01/2016

Ending:

06/30/2017

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,480,004	1
2	Discounts and Allowances for all Levels	(504,081)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,975,923	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	357,788	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 357,788	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	29,284	13
14	Non-Patient Meals	35,215	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	12,000	16
17	Sale of Drugs	24,009	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,108	19
20	Radiology and X-Ray	2,420	20
21	Other Medical Services	68,794	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 175,830	23
D. Non-Operating Revenue			
24	Contributions	6,772,362	24
25	Interest and Other Investment Income***	90	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,772,452	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)	\$ 13,281,993	30

1		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,130,319	31
32	Health Care	1,815,385	32
33	General Administration	2,142,476	33
B. Capital Expense			
34	Ownership	2,509,270	34
C. Ancillary Expense			
35	Special Cost Centers	537,464	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)*	\$ 9,134,914	40
41	Income before Income Taxes (line 30 minus line 40)**	4,147,079	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 4,147,079	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 884,233	44
45	Private Pay - Net Inpatient Revenue	83,690	45
46	Medicare - Net Inpatient Revenue	681,377	46
47	Other-(specify) <u>Insurance</u>	201	47
48	Other-(specify) <u>Assisted/Independent Living</u>	4,326,422	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,975,923	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:

07/01/2016

Ending:

06/30/2017

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	1,800	2,080	\$ 91,057	\$ 43.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,969	13,415	418,852	31.22	3
4	Licensed Practical Nurses	7,310	8,431	195,415	23.18	4
5	CNAs & Orderlies	46,446	50,957	753,358	14.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,941	2,105	67,506	32.07	9
10	Activity Assistants	6,261	6,952	94,970	13.66	10
11	Social Service Workers	1,878	2,054	66,555	32.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	10,086	11,202	243,917	21.77	17
18	Housekeepers	8,982	9,965	156,913	15.75	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,958	3,591	101,684	28.32	22
23	Office Manager	1,859	2,080	56,721	27.27	23
24	Clerical	6,964	7,482	147,146	19.67	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	864	981	14,549	14.83	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	108,318	121,295	\$ 2,408,643 *	\$ 19.86	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	28	1,758	11/3 44
45	Social Service Consultant			45
46	Other(specify)			46
47	Security	4,388	71,178	6/3 47
48	Administrative	2	128	19/3 48
49	TOTAL (lines 35 - 48)	4,418	\$ 73,064	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	
Patricia Campell	Exec Asst	0	\$ 30,671	Workers' Compensation Insurance	\$ 24,231	IDPH License Fee	\$	
Patricia Kouba	HR Coordinator	0	36,367	Unemployment Compensation Insurance	21,492	Advertising: Employee Recruitment	14,538	
Susan Tirpak	HR Manager	0	19,756	FICA Taxes	127,956	Health Care Worker Background Check	200	
Thomas Wogan	Major Gifts Officer	0	14,890	Employee Health Insurance	370,399	(Indicate # of checks performed <u> 2 </u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	6,713	
				Employee Life Insurance	20,437	Licenses & Taxes	526	
				403B Employer Match	49,558	Bank/Trust Acct./Letter of Credit Fees	67,158	
				Employee Appreciation	8,000	Dues/Fees allocated to AL/IL	(53,989)	
				Employee Assistance Program				
				Expense allocated to AL/IL	(160,072)	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 101,684	TOTAL (agree to Schedule V, line 22, col.8)			\$ 35,146	
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	19,172
							First Nat'l Bank - Travel to MI/NE	711
							In-State Travel	
							Miscellaneous Travel	750
							Travel/Seminar Exp. Alloc to AL/IL	(14,572)
							Seminar Expense	
							Activities Training/Seminar	450
							Admin - Conferences	2,757
							First Nat'l Bank - SS/Maint Seminar Exp	218
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							TOTAL	\$ 9,486
C. Professional Services								
Vendor/Payee	Type		Amount					
Point Click Care	billing software		\$ 19,564					
Trinity Senior Living Communities	mgt fees/travel exp/consult		322,420					
Corporation Service Company	Igl svcs - statutory repres.		107					
Plante & Moran, PLLC	financial statement review		45,100					
Trinity Senior Living Communities	Adm salary/benefits		157,970					
Sisters of Mercy - Americas	Access One phone service		888					
Sisters of Mercy - Americas	Leadership wages/benefits		29,892					
Access Media 3	Direct TV		41,142					
Pointright	Clinical Software		5,500					
Shred It	Shredding		1,969					
Unidine	Dietary expense		24,882					
	Misc Exp - see detail		36,127					
TOTAL (agree to Schedule V, line 19, column 3)								
(For legal fee disclosure, see page 39 of instructions)			\$ 685,561					

* Attach copy of IMRF notifications

**See instructions.

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 \$1,062.50
- (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. \$ 4,552 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. \$ 45,649
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. \$ 35,215
- (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 6-30-17

Professional Services			
Trinity Sr. Living Communities	300,000	Management Fee	
Unidine	24,882	Dietary Expense to be reclassified to line 1	
Pointclick Care Tech.	2,594	PCC - Billing/Clinical Software	
Plante and Moran	45,100	Accounting Services, review of Financial Sta	
Shea, Paige and Rogal, Inc.	20,000	Legal Counsel, lifting restrictions of CON	
IL Dept. Public Health	2,500	CON Filing	
Koley Jessin PC, LLO	1,512	Legal services, employment matters	
Jackson Lewis, PC	1,287	Legal services, empl/resident matters	
Socialwork Consult. Group	856	\$128 policy, \$728 activities to be reclassified t	
Trinity Sr. Living Communities	157,970	Administrator salary and benefits	
Trinity Sr. Living Communities	2,660	Consulting - S. Masters on Billing Software	
TSLC - expenses	19,172	Travel	
TSLC - expenses	5,500	Pointright - Clinical Software	
TSLC - expenses	500	Unemployment Quarterly Billing	
TSLC - expenses	351	Reference Materials	
TSLC - expenses	(262)	Supply rebate	
Access Media 3, Inc.	41,142	HD Direct TV Programming	
AG Architecture	600	Additional Bed	
Sisters of Mercy Americas	29,892	Allocation from Sisters of Mercy	
Sisters of Mercy Americas	16,970	PCC - Billing/Clinical software	
Sisters of Mercy Americas	888	Access One - Phone Service	
Careworx Corporation	96	Maintenance on Clinical Kiosks, reclass to lii	
Jeff Harris & Associates, Inc.	2,500	Recruiting Service	
Kathleen Gordon Davis	30	Art Class, reclass to line 11	
Shred-It USA LLC	1,969	Shredding Services	
Accruals	6,747		
Corporation Service Comp.	107	Statutory Representation	
Total	685,561		

Dues, Fees, Subscriptions

			Est	
			# Checks	
Background Checks				
IL State Police	<u>200</u>	9/7/2016	<u>2</u>	Reclass from Social Services
	200	200	2	
Sales & Marketing	113,696	-113696	-	Remove as nonallowable
Adv./Empl Recruit	14,788	-250	14,538	
Dues & Subscriptions	6,713		6,713	
IDPH License Fee			-	
Licenses & Fees	43,053	-42527	526	
Bank/Trust Act/LOC	67,157		67,157	
Fines & Penalties	<u>120</u>	<u>-120</u>	<u>0</u>	Remove as nonallowable

Allocated to AL/IL	245,528	(156,393)	89,135
Net			(53,989)
			35,146

Leased Equipment		
Cannon Finan Svcs	4,542	Graphic Equipment
	151	Late charges to be removed.
Martin Whalen Office Sol.	548	Copier
Pitney Bowes Global	1,404	Postage Meter
Proven Business Solutions	5,232	Maintenance of Copiers, reclass to line 6
Careworx Tech	105	Maintenance of Clinical Kiosks for Doc., reclass to line 6
Southern Comp. W/H	182	External Drive, reclass to line 21
Total	12,165	
Adjusted Leased Equip., L. 35	6,494	

Employee Benefits	Line 22		Adjusted
Employee Benefits/Pa	Col. 3	Col. 7	
Workers Compensatio	24,231		24,231
Unemployment Comp.	21,493		21,493
FICA Taxes	172,332	(44,376)	127,956
Employee Health Insu	380,195	(2,552)	377,643
Employee Life Insuran	20,437		20,437
Employee Pension			-
403B Employer Match	49,558		49,558
Employee Appreciatio	8,000	-	8,000
	<u>676,246</u>	<u>(46,928)</u>	<u>629,318</u>

Col 7 adjustment reflects removal of direct AL/IL expense.

Travel			
Payroll	39	Activities	Mileage
First Nat'l Bank Omah:	343	Admin	Travel/Lodging Omaha, NE
First Nat'l Bank Omah:	368	Maintenance	Travel/Lodging Muskegon, MI
First Nat'l Bank Omah:	22	Maintenance	Oil Change/Car wash
Petty Cash	40	Maintenance	Reimb for local travel
Payroll	340	Admin	Reimb for local travel
Payroll	219	Maintenance	Mileage Tannura, Vincent
Payroll	89	Admin	Reimb Meals
TSLC - out of State	-	Admin	Travel of TSLC employees to Mercy Circle
Total Travel	1,461		

Training/Seminars			
First Nat'l Bank Omah:	450	Activities	Quality Therapy & Consultation
First Nat'l Bank Omah:	59	AL	Online course - safe food handling
First Nat'l Bank Omah:	30	AL	Online course - safe food handling
First Nat'l Bank Omah:	198	Admin	Online course - safe food handling
First Nat'l Bank Omah:	49	Admin	Leading Age IL Conference
First Nat'l Bank Omah:	99	Admin	Leading Age IL Training
First Nat'l Bank Omah:	1,210	Admin	Leading Age IL Conference
First Nat'l Bank Omah:	585	Admin	Leading Age IL Training for 3 people
First Nat'l Bank Omah:	198	Admin	Leading Age IL Training
Adjustment	160	Admin	
First Nat'l Bank Omah:	258	Admin	HIN (Health Info Network) 2 seminars online
Petty Cash	45	Nursing Adm	CPR Cart Nursing Supply, reclass to L. 10
Petty Cash	4	Nursing Adm	Distilled Water Nursing Supply, reclass to L. 10
Petty Cash	16	Nursing Adm	Distilled Water Nursing Supply, reclass to L. 10
First Nat'l Bank Omah:	18	Social Serv	Daily Reflection Books
First Nat'l Bank Omah:	199	Maintenance	Life Safety Code Seminar, Chicago, IL
	3,579		

tements

o line 11

ne 6

Mercy Circle
 Consultants
 FYE 6-30-17

Activities	Hours	\$
42551 Socialwork Consultation Group	4.5	283.5
42643 Socialwork Consultation Group	5.25	330.75
42674	5	315
42704	3.5	220.5
42794	3	192
42855	6.5	416
Total	27.75	1757.75

Admin	Hours	\$
42825 Socialwork Consultation Group	2	128

Maintenance Date	Hours	\$
42534 Excel Security Services, Inc.	88	1418.56
42541	84	1354.08
42548	88	1418.56
42555	84	1394.56
42562	84	1354.08
42569	84	1354.08
42577	84	1354.08
42583	84	1302
42593	84	1302
42598	84	1302
42604	84	1354.08
42611	84	1354.08
42621	84	1364
42625	84	1333
42633	84	1354.08
42660	84	1354.08
42653	84	1354.08
42639	84	1354.08
42646	84	1354.08
42674	84	1354.08
42681	84	1354.08
42688	84	1354.08
42702	84	1450.8
42695	84	1354.08
42710	84	1354.08
42716	84	1354.08
42723	88	1450.8
42731	85	1474.98
42744	84	1354.08
42738	84	1450.8
42751	84	1354.08
42758	84	1354.08
42765	84	1354.08
42772	84	1354.08
42779	84	1354.08
42786	84	1354.08
42793	84	1354.08
42800	84	1354.08
42807	84	1354.08
42814	84	1354.08
42821	84	1354.08
42828	90	1499.16
42835	84	1344
42842	84	1450.8
42849	84	1354.08
42856	84	1354.08
42863	84	1354.08
42870	84	1354.08
42877	84	1354.08
42884	85	1442.74
42891	84	1386.32
42898	84	1354.08
Total	4388	71177.88

Mercy Circle
Adjustments to Expense
FYE 6-30-17

Direct Expense for AL/IL and MC		
<u>Description</u>	<u>Amount</u>	<u>Line #</u>
Supplies/Briefs	(4,964)	10
Forms/Misc	(9)	21
Nursing Wages	(621,596)	10
Activities Wages	(190)	11
Recruit/Fees	(250)	20
Benefits	(46,928)	22
Training/Seminars	(89)	24
Maintenance	(81)	6
Physician Fees	(6,360)	9
Medical Supplies	(150)	39
Equip Lease	<u>-</u>	35
Total	(680,618.21)	

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	1,181,023	178,724	42,409	219,112	490,462	175,677	67,082	101,684	640,653	89,135	294,583	24,058	63,229	1,109,064	1,267,951	6,495	5,951,341
Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Expense to Alloc	1,181,023	178,724	42,409	219,112	490,462	175,677	67,082	101,684	640,653	89,135	294,583	24,058	63,229	1,109,064	1,267,951	6,495	5,951,341

Direct Expense

AL	615,815	58,440.39	27,705	54,853	122,784	114,766	17,055	43,074	271,384	37,758	124,787	10,191	26,784	-	-	-	1,525,397
IL	238,367	73,322	-	120,179	269,010	-	1,137	18,516	116,658	16,231	53,641	4,381	11,514	877,193	1,045,352	5,355	2,850,857
SNF	326,840	46,962	14,704	44,079	98,667	60,911	48,890	40,094	252,611	35,146	116,155	9,486	24,931	231,871	222,599	1,140	1,575,087
Total	1,181,023	178,724	42,409	219,112	490,462	175,677	67,082	101,684	640,653	89,135	294,583	24,058	63,229	1,109,064	1,267,951	6,495	5,951,341

Benefits

AL		13,251			15,771	27,413	4,370	11,125			22,304						94,233
IL		16,626			34,552	-	291	4,782			9,588						65,839
SNF		10,648			12,673	14,549	12,528	10,355			20,761						81,514
Total		40,525			62,996	41,962	17,189	26,262			52,652						241,586

Statistic	Meals	Adj Sq Ftg	Patient Da	Sq Footag	Sq Footag	Patient Da	Discharges	Accum Cost	Depr Exp	Bldg Cost	Bldg Cost					
AL	40,545	30,160	13,515	30,160	30,160	13,515	15	680,618	680,618	680,618	680,618	680,618	680,618			
IL	15,694	37,840	-	66,078	66,078	-	1	-	-	-	-	-	-	877,194	32,940,213	32,940,213
SNF	21,519	24,236	7,173	24,236	24,236	7,173	43	940,139	940,139	940,139	940,139	940,139	940,139	231,871	7,014,328	7,014,328
Total	77,758	92,236	20,688	120,474	120,474	20,688	59	1,620,757	1,620,757	1,620,757	1,620,757	1,620,757	1,620,757	1,109,065	39,954,541	39,954,541

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.

Mercy Circle
 Adjustments to Expense
 FYE 6-30-17

<u>Description</u>	<u>Amount</u>	<u>Line #</u>		
Meal Income	(35,215)	1	Administrative/LTC only	
Garage/Parking Fees	(12,000)	6		
Miscellaneous Revenue	(2,122)	21		
Postage/Jury Duty/Tel	(97)	21		
Catering Income	(697)	1		Revenue Offsets
Maintenance Misc Rev	(925)	6		
Benefits	(7,245)	22		
Interest Income	(90)	32		
Bad Debt Expense	(68,545)	27	Income tax refund applies to prior period, income tax never claimed on Medicaid cost report. Removing refund.	
Income Tax Refund	3,274	20		
Marketing Expense	(113,696)	20		F/S Expense Offsets
Fines & Penalties	(120)	20		
Late Fee - Bed Tax	(152)	20		
Late Fee - Lease Payment	(151)	35		
PR Expense	-	19		
Provider Participation Fee	45,649	42	Reclasses of expense	
	(45,649)	20		
Background Checks Fee	200	20		
	(200)	12		
Activities	1,042	11		
	(284)	10		
	(758)	19		
Maintenance Expense	5,433	6		
	(96)	19		
	(5,337)	35		
General Supplies	182	21		
	(182)	35		
Dietary Expense	24,882	1		
	(24,882)	19		
TSLC Travel	19,172	24		
	(19,172)	19		
Nursing Supplies	65	10		
	(65)	24		
Maintenance Repair	14	6		
	(14)	21		

Mercy Circle
Fixed Asset Schedule
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	Depr 6/30/17	A/D 6/30/17
2014	Building - Initial Cost	6,537,662		40	163,442	108,961	163,442	272,403	163,442	435,844	163,442	599,286
2015	Aluminum Logo Sign	631		10	63	-	58	58	63	121	63	184
		6,538,294				108,961	163,499	272,460	163,505	435,965	163,505	599,470
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	29,980	109,927
2014	Staff Computers - opening	6,355		5	1,271	847	1,271	2,118	1,271	3,389	1,271	4,660
2014	Office Phones - Shoretel	783		5	157	104	157	261	157	418	157	574
2014	Plant Ops Smallwares	4,071		5	814	543	814	1,357	814	2,171	814	2,985
2014	Medical Equip Smallwares	23,962		5	4,792	399	4,792	5,192	4,792	9,984	4,792	14,777
2014	AL Televisions & Wall Mounts	-		5	-	-	-	-	-	-	-	-
2014	Kitchen Hood	276		5	55	37	55	92	55	147	55	202
		335,248					37,070	58,987	37,070	96,056	37,070	133,126
2015	Dynatronics - Rnd Ped Table	93		10	9		5	5	9	15	9	24
2015	Nativity Scene	192		10	19		11	11	19	30	19	49
2015	Multi Purp Rack & H/L Eco-Line	985		10	99		49	49	99	148	99	246
2015	Evaporator Fan Motor	130		10	13		3	3	13	16	13	29
2015	Eco Mat Table	64		5	13		10	10	13	22	13	35
2015	Combo-Stim Ultrasound	3,295		5	659		494	494	659	1,153	659	1,812
2015	Recumbent Stepper	3,795		15	253		190	190	253	443	253	696
2015	Upper Body Exerciser	3,455		5	691		518	518	691	1,209	691	1,900
2015	Parallel Bars	765		10	77		57	57	77	134	77	210
2015	Treadmill	1,135		8	142		106	106	142	248	142	390
	FY2015	13,908					1,445	1,445	1,974	3,419	1,974	5,393
2016	Samsung TV	126		5	25				11	11	25	36
2016	Oxygen Concentrator Machine	2,024		7	289				72	72	289	361
2016	Oxygen Concentrator Machine	2,284		7	326				82	82	326	408
2016	Dell Optiplex 3240	798		5	160				13	13	160	173
2016	Simplex Nurse Call System	5,105		7	729				61	61	729	790
	FY2016	10,338							238	238	1,530	1,768
2017	Dell i3 6100u Laptop PC	655		5	131						131	131
2017	Dell External USB DVD Drive	53		5	11						11	11
2017	Dell Latitude E6440 Laptop PC	1,094		5	219						219	219
2017	First Security System	-		5	-						-	-
2017	First Security System	-		5	-						-	-
2017	Dell	1,600		5	320						27	27
2017	First Security System	-		5	-						-	-
2017	Key Carpet	-		10	-						-	-
2017	SNF Security System- Upgrade	5,274		10	527						440	440
	FY2017	8,675									826	826
Vehicles												
2007	Toyota Avalon	12,171		4	3,043	254	3,043	3,296	3,043	6,339	3,043	9,382
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	3,586	11,057
2013	14 Passenger Bus	55,317		4	13,829	9,219	13,829	23,049	13,829	36,878	13,829	50,707
2013	Dodge Ram Truck	26,033		4	6,508	4,339	6,508	10,847	6,508	17,355	6,508	23,864
		114,822	(6,957)			14,111	25,915	41,077	26,966	68,043	26,966	95,009
	Bldg	6,538,294				108,961	163,499	272,460	163,505	435,965	163,505	599,470
	Equip/Vehicles	476,034				14,111	64,429	101,509	66,248	167,757	68,366	236,123
					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
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	807,699	2,961,563
2015	Aluminum Logo Sign	3,119		10	312	-	286	286	312	598	312	910
		32,311,084				538,466	807,985	1,346,451	808,011	2,154,462	808,011	2,962,473
Equipment												
2014	Initial Purchase IL/Commons	261,826		10	26,183	17,455	26,183	43,638	26,183	69,820	26,183	96,003
2014	Initial Purchase AL/SNF	291,093		10	29,109	19,406	29,109	48,515	29,109	77,625	29,109	106,734
2014	Staff Computers - opening	31,406		5	6,281	4,187	6,281	10,469	6,281	16,750	6,281	23,031
2014	Office Phones - Shoretel	3,870		5	774	516	774	1,290	774	2,064	774	2,838
2014	Plant Ops Smallwares	20,118		5	4,024	2,682	4,024	6,706	4,024	10,730	4,024	14,753
2014	Medical Equip Smallwares	-		5	-	-	-	-	-	-	-	-
2014	AL Televisions & Wall Mounts	6,768		5	1,354	902	1,354	2,256	1,354	3,610	1,354	4,964
2014	Kitchen Hood	1,362		5	272	182	272	454	272	726	272	999
		616,443					67,997	113,328	67,997	181,325	67,997	249,321
2015	Dynatronics - Rnd Ped Table	461		10	46	-	26.88	27	46	73	46	119
2015	Nativity Scene	946		10	95	-	55.21	55	95	150	95	244
2015	Multi Purp Rack & H/L Eco-Lin	4,869		10	487	-	243.44	243	487	730	487	1,217
2015	Evaporator Fan Motor	640		10	64	-	16.01	16	64	80	64	144
2015	Eco Mat Table	315		5	63	-	47.28	47	63	110	63	173
2015	Combo-Stim Ultrasound	-		5	-	-	-	-	-	-	-	-
2015	Recumbent Stepper	-		15	-	-	-	-	-	-	-	-
2015	Upper Body Exerciser	-		5	-	-	-	-	-	-	-	-
2015	Parallel Bars	-		10	-	-	-	-	-	-	-	-
2015	Treadmill	-		8	-	-	-	-	-	-	-	-
	FY2015	7,232					389	389	755	1,143	755	1,898
2016	Samsung TV	625		5	125	-	-	-	52	52	125	177
2016	Oxygen Concentrator Machine	-		7	-	-	-	-	-	-	-	-
2016	Oxygen Concentrator Machine	-		7	-	-	-	-	-	-	-	-
2016	Dell Optiplex 3240	-		5	-	-	-	-	-	-	-	-
2016	Simplex Nurse Call System	-		7	-	-	-	-	-	-	-	-
	FY2016	625							52	52	125	177
2017	Dell i3 6100u Laptop PC	-		5	-	-	-	-	-	-	-	-
2017	Dell External USB DVD Drive	-		5	-	-	-	-	-	-	-	-
2017	Dell Latitude E6440 Laptop PC	-		5	-	-	-	-	-	-	-	-
2017	First Security System	1,370		5	274	-	-	-	-	137.00	274	370
2017	First Security System	1,472		5	294	-	-	-	-	98.12	294	392
2017	Dell	-		5	-	-	-	-	-	-	-	-
2017	First Security System	463		5	93	-	-	-	-	7.72	93	124
2017	Key Carpet	1,525		10	153	-	-	-	-	63.54	153	203
2017	SNF Security System- Upgrad	-		10	-	-	-	-	-	-	-	-
	FY2017	4,830								306	483	644
Vehicles												
2007	Toyota Avalon	-		4	-	-	-	-	-	-	-	-
2006	Ford 500SE	-		4	-	-	-	-	-	-	-	-
2010	Toyota Camry	-		4	-	-	-	-	-	-	-	-
2013	14 Passenger Bus	-		4	-	-	-	-	-	-	-	-
2013	Dodge Ram Truck	-		4	-	-	-	-	-	-	-	-
		-										
	Bldg	32,311,084				538,466	807,985	1,346,451	808,011	2,154,462	808,011	2,962,473
	Equip/Vehicles	629,129				-	68,386	113,717	68,803	182,520	69,183	251,703