

Facility Name & ID Number Mercy Rehab and Care Center

0032680 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,284	11,910	5,791	34,985	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,284	11,910	5,791	34,985	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.87%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/08/1987

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/08/1987 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 120 and days of care provided 3,123

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2018 Fiscal Year: 06/30/2018

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	249,744	39,147	9,838	298,729		298,729		298,729		1
2	Food Purchase		242,146		242,146		242,146	(2,394)	239,752		2
3	Housekeeping	194,105	37,677		231,782		231,782		231,782		3
4	Laundry	59,230	9,229		68,459		68,459		68,459		4
5	Heat and Other Utilities			145,961	145,961		145,961		145,961		5
6	Maintenance	106,236	20,401	89,455	216,092		216,092	24,502	240,594		6
7	Other (specify):* Waste Disposal			26,787	26,787		26,787		26,787		7
8	TOTAL General Services	609,315	348,600	272,041	1,229,956		1,229,956	22,108	1,252,064		8
	B. Health Care and Programs										
9	Medical Director			10,046	10,046		10,046		10,046		9
10	Nursing and Medical Records	2,393,585	247,902	141,062	2,782,549		2,782,549		2,782,549		10
10a	Therapy	66,569	647		67,216		67,216		67,216		10a
11	Activities	61,019	8,506	2,592	72,117		72,117		72,117		11
12	Social Services	75,978		2,952	78,930		78,930		78,930		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,597,151	257,055	156,652	3,010,858		3,010,858		3,010,858		16
	C. General Administration										
17	Administrative	93,636			93,636		93,636		93,636		17
18	Directors Fees										18
19	Professional Services			16,934	16,934		16,934		16,934		19
20	Dues, Fees, Subscriptions & Promotions			36,890	36,890	(1,753)	35,137	(10,508)	24,629		20
21	Clerical & General Office Expenses	226,937	25,493	113,217	365,647		365,647	(19)	365,628		21
22	Employee Benefits & Payroll Taxes			553,304	553,304		553,304		553,304		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,900	2,900	1,753	4,653		4,653		24
25	Other Admin. Staff Transportation			3,493	3,493		3,493		3,493		25
26	Insurance-Prop.Liab.Malpractice			80,555	80,555		80,555	20,538	101,093		26
27	Other (specify):*										27
28	TOTAL General Administration	320,573	25,493	807,293	1,153,359		1,153,359	10,011	1,163,370		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,527,039	631,148	1,235,986	5,394,173		5,394,173	32,119	5,426,292		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Rehab and Care Center

#0032680

Report Period Beginning:

07/01/17

Ending:

06/30/18

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			36,611	36,611		36,611	190,935	227,546			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,257	33,257		33,257	495,450	528,707			32
33	Real Estate Taxes							73,305	73,305			33
34	Rent-Facility & Grounds			798,000	798,000		798,000	(798,000)				34
35	Rent-Equipment & Vehicles			34,115	34,115		34,115		34,115			35
36	Other (specify):*											36
37	TOTAL Ownership			901,983	901,983		901,983	(38,310)	863,673			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		151,228	660,190	811,418		811,418		811,418			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			257,962	257,962		257,962		257,962			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		151,228	918,152	1,069,380		1,069,380		1,069,380			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,527,039	782,376	3,056,121	7,365,536		7,365,536	(6,191)	7,359,345			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	(2,394)	2		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	(6,459)	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	(33,257)	32		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	(19)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,884)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(274)	20		28
29	Other-Attach Schedule	(2,850)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (52,637)		\$	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)	46,446		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 46,446		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (6,191)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

BHF USE ONLY							
48		49		50		51	52

Mercy Rehab and Care Center

ID# 0032680

Report Period Beginning: 07/01/17

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate Lobbying & PAC Dues	\$ (2,850)	20	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,850)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Rehab and Care Center

0032680

Report Period Beginning:

07/01/17

Ending:

06/30/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,394)	0	0	0	0	0	0	0	0	0	0	(2,394)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	24,502	0	0	0	0	0	0	0	0	0	24,502	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,394)	24,502	0	22,108	8								
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
C. General Administration														
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(10,508)	0	0	0	0	0	0	0	0	0	0	(10,508)	20
21	Clerical & General Office Expenses	(19)	0	0	0	0	0	0	0	0	0	0	(19)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	20,538	0	0	0	0	0	0	0	0	0	20,538	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(10,527)	20,538	0	10,011	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(12,921)	45,040	0	32,119	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mercy Rehab and Care Center

0032680

Report Period Beginning:

07/01/17

Ending:

06/30/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	190,935	0	0	0	0	0	0	0	0	0	190,935	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(39,716)	535,166	0	0	0	0	0	0	0	0	0	495,450	32
33	Real Estate Taxes	0	73,305	0	0	0	0	0	0	0	0	0	73,305	33
34	Rent-Facility & Grounds	0	(798,000)	0	0	0	0	0	0	0	0	0	(798,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(39,716)	1,406	0	(38,310)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(52,637)	46,446	0	(6,191)	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
Rosewood Care Center Holding Co.	100	N/A		SILDA LLC	St. Louis, MO	Real Estate Lsg.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 798,000	SILDA LLC		\$	(798,000)	1
2	V	6 Maintenance		SILDA LLC		24,502	24,502	2
3	V	26 Property Insurance		SILDA LLC		20,538	20,538	3
4	V	30 Depreciation		SILDA LLC		190,935	190,935	4
5	V	32 Interest		SILDA LLC		535,166	535,166	5
6	V	33 Real Estate Taxes		SILDA LLC		73,305	73,305	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 798,000			\$ 844,446	\$ * 46,446	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Mercy Rehab and Care Center

0032680

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07/01/17

Ending:

06/30/18

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/17 Ending: 06/30/18

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	Schedule N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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0032680

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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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Mercy Rehab and Care Center

0032680

Report Period Beginning:

07/01/17

Ending:

06/30/18

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**					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	St. Louis Bank		X	Mortgage	\$65,394.00	08/28/15	\$ 13,600,000	\$ 11,636,400	08/28/20	4.0000	\$ 535,166	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6		X		Miscellaneous							33,257	6						
7												7						
8												8						
9	TOTAL Facility Related				\$65,394.00		\$ 13,600,000	\$ 11,636,400			\$ 568,423	9						
B. Non-Facility Related*																		
10				Interest Income							(6,459)	10						
11				Related Party Interest							(33,257)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (39,716)	14						
15	TOTALS (line 9+line14)						\$ 13,600,000	\$ 11,636,400			\$ 528,707	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2017 report.		\$	74,000	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.)		\$	73,305	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(695)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	74,000	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.		\$	73,305	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	63,080	8	
	2014	64,735	9	
	2015	69,254	10	
	2016	72,775	11	
	2017	73,835	12	
Line 2: 2nd installment of 2016 taxes \$36,387.47 and 1st installment of 2017 taxes \$36,917.50 = \$73,305 paid				
Line 4: 1/2 of the 2017 taxes due plus 1/2 of the estimated 2018 taxes due.				

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mercy Rehab and Care Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0032680

CONTACT PERSON REGARDING THIS REPORT Cindy Tefteller

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-09.0-402-023</u>	<u>Wandering Woods</u>	\$ <u>73,835.32</u>	\$ <u>73,835.32</u>
2. _____	<u>Lot/SEC-3 A02410700</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>73,835.32</u></u>	\$ <u><u>73,835.32</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Mercy Rehab and Care Center

0032680 Report Period Beginning:

07/01/17 Ending:

06/30/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,331 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

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

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	<u>Nursing Home</u>		<u>1987</u>	<u>\$ 126,031</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 126,031	3

SEE ACCOUNTANTS' PREPARATION REPORT

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	102			1987	\$ 2,175,969	\$	20-25	\$	\$	\$ 2,175,969	4
5	10			1988	253,539		25			253,539	5
6	8			1990	222,972		25			222,972	6
7				1991	6,679		25			6,679	7
8											8
	Improvement Type**										
9	Walk in Cooler			1987	5,515		10			5,515	9
10	Exhaust Hood			1987	6,498		10			6,498	10
11	Paging Systems			1987	632		10			632	11
12	Carpet			1987	39,910		10			39,910	12
13	Hospital Track/Curtains			1987	8,075		10			8,075	13
14	Signs			1987	2,916		10			2,916	14
15	Telephone Equipment			1987	3,180		10			3,180	15
16	Outside Sign			1987	4,504		10			4,504	16
17	Water Heater			1987	3,650		10			3,650	17
18	Walk in Freezer			1988	3,936		15			3,936	18
19	Nurse Call System			1988	670		15			670	19
20	Signs			1989	2,000		10			2,000	20
21	Exhaust Fan			1989	530		10			530	21
22	Water Treatment System			1989	5,905		10			5,905	22
23	Door Guards			1989	5,509		10			5,509	23
24	Corner Guards			1990	1,446		10			1,446	24
25	Carpeting			1990	2,215		10			2,215	25
26	Hot Water Storage			1996	2,607		10			2,607	26
27	Landscaping/Fencing			1987	25,279		25			25,279	27
28	Water Hydrant			1988	1,677		10			1,677	28
29	Trees and Seeding			1988	745		10			745	29
30	Seeding			1988	4,290		10			4,290	30
31	Parking Lot Expansion			1988	621		25			621	31
32	Road			1990	431,970		25			431,970	32
33	Parking Lot Expansion			1989	27,592		15			27,592	33
34	Landscaping/Fencing			1989	1,904		25			1,904	34
35	Lawn Sprinkler System			1992	10,926		25	109	109	10,926	35
36	Backflow for Sprinkler			1993	2,909		25	101	101	2,909	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center

0032680

Report Period Beginning:

07/01/17

Ending:

06/30/18

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Sinks	1987	\$ 4,156	\$	10	\$	\$	\$ 4,156	37
38	Hand Sinks	1987	181		10			181	38
39	Heat Pumps	2003	3,746		10			3,746	39
40	Roof Work	2004	21,620		40	541	541	7,568	40
41	Storage Building	2004	13,980		25	559	559	7,642	41
42	Parking Lot Seal & Stripe	2004	3,993		2			3,993	42
43	Telephone Power Pole	2005	10,875		10			10,875	43
44	Fire Alarm System	2005	9,668		10			9,668	44
45	Satellie System	2006	9,002		10			9,002	45
46	Heat Pumps	2007	37,285		10			37,285	46
47	Evaporative Cooling Table	2007	48,252		10			48,252	47
48	Water Heater	2007	3,545		10	59	59	3,545	48
49	Compressor Blower Motor	2007	2,938		10	25	25	2,938	49
50	Water Heater	2007	3,595		10	90	90	3,595	50
51	Electrical Wiring	2009	3,153		10	315	315	2,969	51
52	Painting Exterior Building	2010	8,792		10	220	220	1,777	52
53	Heat Pumps	2009	6,327		10	633	633	5,484	53
54	Exterior Doors	2009	9,014		10	901	901	7,812	54
55	Wall Cabinets	2009	1,009		10	101	101	875	55
56	Sprinkler Pipe	2010	14,909		10	1,491	1,491	12,300	56
57	Water Heater	2010	4,040		10	404	404	3,299	57
58	Cooling Tower Fan	2011	4,554		10	455	455	3,225	58
59	Seal & Stripe Parking Lot	2010	4,839		25	194	194	1,484	59
60	Heat Pumps	2012	5,218		10	522	522	3,305	60
61	Replace Interior/Exterior Doors	2013	6,951		10	695	695	3,533	61
62	Purchase & Install 8 Doors	2013	3,476		40	87	87	415	62
63	Water Heater	2015	6,699		10	670	670	2,177	63
64	A/C's/Heat Pumps	2015	5,310		10	531	531	1,814	64
65	Landscaping	2013	3,310		25	132	132	617	65
66	Landscaping	2015	5,375		25	215	215	645	66
67	A/C Units	2015	14,019		10	1,402	1,402	4,089	67
68	3 Heat Pumps	2016	8,240		10	824	824	1,923	68
69	Cooling Tower Coil	2016	29,740		10	2,974	2,974	6,196	69
70	TOTAL (lines 4 thru 69)		\$ 3,584,581	\$		\$ 14,250	\$ 14,250	\$ 3,483,155	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Mercy Rehab and Care Center

0032680

Report Period Beginning:

07/01/17

Ending:

06/30/18

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,584,581	\$		\$ 14,250	\$ 14,250	\$ 3,483,155	1
2	7 A/C Units	2016	17,813		10	1,781	1,781	3,563	2
3	Shrubs, Plastic, Rock & Mulch for Flower Beds	2017	10,280		25	411	411	514	3
4	TV Mounts	2016	2,579		10	368	368	553	4
5	Complete renovation of rooms 415-418, Carpentry, Flooring								5
6	Painting, handrails, plumbing, and electrical	2016	55,490		15	3,699	3,699	5,549	6
7	Flooring - Utility Room, Laundry Room & Break Rooms	2017	19,342		15	1,289	1,289	1,397	7
8	Tile - Lobby, Nurse Stations & Dining Rooms	2017	7,598		15	507	507	507	8
9	Heat Pump	2016	10,900		10	1,090	1,090	1,998	9
10	Evaporator Coils for Cooling Tower	2016	1,772		10	177	177	325	10
11	10 AC/Heating E-Tac Units	2016	15,496		10	1,550	1,550	2,454	11
12	Install 5 Heater Units	2016	3,443		10	344	344	516	12
13	Heat Pumps for Dining Toom & 200 Hallway	2017	22,600		10	2,260	2,260	2,448	13
14	New Boiler	2017	57,930		10	5,793	5,793	7,241	14
15	Install PTACs - Century	2017	3,707		10	370	370	370	15
16	Purchase & Install 51 E TAC Units	2017	138,355		10	13,836	13,836	13,836	16
17	New Dry Pendants & Pipes for Sprinkler System	2017	26,993		10	2,699	2,699	2,699	17
18	Hot Water Heater	2017	10,678		10	1,068	1,068	1,068	18
19	Heat Pump - Laundry Hallway	2017	12,796		10	1,280	1,280	1,280	19
20	Carpet/Tile/Painting - Nurses Call Station	1993	20,471		7			20,471	20
21	Painting/Wallpaper	1994	15,422		7			15,422	21
22	Painting/Wallpaper/Tile	1995	25,375		7			25,375	22
23	Shelving	1995	2,186		7			2,186	23
24	New Upholstery	1995	513		7			513	24
25	Design Work	1995	128		7			128	25
26	Carpeting	1996	5,580		7			5,580	26
27	Painting/Tiling	1996	6,383		7			6,383	27
28	Painting	1997	3,025		7			3,025	28
29	Tile & Base 2 Rooms	1997	1,400		7			1,400	29
30	2 Oak Doors	1997	803		7			803	30
31	Carpet & Installation	1998	7,951		7			7,951	31
32	Shower Renovations	1998	16,869		7			16,869	32
33	Paint/Wallpaper/Tile Removal	1998	1,833		7			1,833	33
34	TOTAL (lines 1 thru 33)		\$ 4,110,292	\$		\$ 52,772	\$ 52,772	\$ 3,637,412	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Mercy Rehab and Care Center

0032680

Report Period Beginning:

07/01/17

Ending:

06/30/18

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,110,292	\$		\$ 52,772	\$ 52,772	\$ 3,637,412	1
2	Shower Room	1998	18,424		7			18,424	2
3	Wallpaper	1998	273		7			273	3
4	Painting	1998	970		7			970	4
5	Wallpaper	1998	5,103		7			5,103	5
6	Carpet/Installation	1998	5,106		7			5,106	6
7	Phone System	1998	8,703		7			8,703	7
8	Wallpaper	1998	4,450		7			4,450	8
9	Drapery	2000	31,964		7			31,964	9
10	Computer Cabling	2000	2,392		7			2,392	10
11	Painting	2001	18,240		7			18,240	11
12	Cabling	2001	606		7			606	12
13	Carpet	2002	1,150		7			1,150	13
14	Wallcovering	2004	3,554		7			3,554	14
15	Drywall	2004	6,594		7			6,594	15
16	Shelving	2004	2,271		7			2,271	16
17	Tile & Base 2 Rooms	2004	5,918		7			5,918	17
18	Floor Tile & Base	2005	4,203		7			4,203	18
19	Parking Lot Striping & Sealing	2005	3,993		7			3,993	19
20	Repair Water Damaged Rooms	2005	6,141		7			6,141	20
21	Drapes	2006	4,666		7			4,666	21
22	Carpet	2009	13,379		7			13,379	22
23	Water Heater	2011	4,780	684	7	684		4,613	23
24	Telephone System	2011	27,729	3,960	7	3,960		26,761	24
25	Cooling Tower Fan Motor Repair	2011	4,554	647	7	647		4,554	25
26	3 Door Freezer	2013	5,056	722	7	722		5,055	26
27	Flooring - 400, 500 corridors, 100/200 & 400/500 nurses station	2013	4,916	702	7	702		3,627	27
28	(cont.) main & assisted dining rooms, mechanical wing								28
29	(cont.) therapy wing, 500 corridor bathing suite, rooms 501,								29
30	(cont.) 503, 402, 404, 516, & 517								30
31	Lobby Floor	2014	2,200	314	7	314		1,148	31
32	Lobby Walls	2014	3,400	486	7	486		1,701	32
33	Parking Lot Paved	2015	4,980	712	7	712		2,136	33
34	TOTAL (lines 1 thru 33)		\$ 4,316,007	\$ 8,227		\$ 60,999	\$ 52,772	\$ 3,835,107	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Mercy Rehab and Care Center

0032680

Report Period Beginning:

07/01/17

Ending:

06/30/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,316,007	\$ 8,227		\$ 60,999	\$ 52,772	\$ 3,835,107	1
2	PTAC Units and Installation	2017	14,209		10	1,066	1,066	13,144	2
3	Paging System	2017	4,952		10	371	371	371	3
4	Replace Make Up Air Unit in Kitchen	2017	32,040		10	2,403	2,403	2,403	4
5	ETAC Units	2017	10,811		10	811	811	811	5
6	Expansion Valve	2017	1,283		10	86	86	86	6
7	Dish Machine Motor Assembly	2017	3,014		10	201	201	201	7
8	PTAC installation	2017	3,200		10	187	187	187	8
9	Complete remodel of all rooms except 415-418, Carpentry	2017	1,571,704		15	61,080	61,080	61,080	9
10	Flooring, Painting, Handrails, Plumbing, and Electrical								10
11	Patching Walls from PTAC Installations	2017	28,158		10	1,877	1,877	1,877	11
12	Fire Sprinkler System	2017	71,177		10	4,152	4,152	4,152	12
13	Relocate A/C to Reception Area	2017	16,875		10	1,266	1,266	1,266	13
14	White Oak Construction	2017	4,729		10	355	355	355	14
15	Nurse Call System	2018	104,893		10	1,748	1,748	1,748	15
16	Complete remodel of all shower rooms - Carpentry,	2018	219,261		15	4,872	4,872	4,872	16
17	Flooring, Painting, Plumbing, Electrical								17
18	A/C Kitchen	2018	28,528		10				18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,430,841	\$ 8,227		\$ 141,474	\$ 133,247	\$ 3,927,660	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Mercy Rehab and Care Center

0032680

Report Period Beginning:

07/01/17

Ending:

06/30/18

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	\$ 402,698	\$ 16,590	\$ 59,136	\$ 42,546	7	\$ 112,409	71
72	Current Year Purchases	177,969	6,540	21,682	15,142	7	21,682	72
73	Fully Depreciated Assets	395,800					395,800	73
74								74
75	TOTALS	\$ 976,467	\$ 23,130	\$ 80,818	\$ 57,688		\$ 529,891	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	Facility Use	2014 Bus	2014	\$ 36,777	\$ 5,254	\$ 5,254	\$	7	\$ 19,265	76
77										77
78										78
79										79
80	TOTALS			\$ 36,777	\$ 5,254	\$ 5,254	\$		\$ 19,265	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)	\$ 7,570,116	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,611	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 227,546	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 190,935	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,476,816	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2	hrs				647		647	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescripts				151,228		151,228	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>PT, OT, ST, Lab, Xray</u>	39, 3				660,190			660,190	13
14	TOTAL			\$		\$ 660,190	\$ 151,875		\$ 812,065	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/18

(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	\$ 391,011	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,087,867		3
4	Supply Inventory (priced at)	5,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	23,815		6
7	Other Prepaid Expenses	21,622		7
8	Accounts Receivable (owners or related parties)	5,253		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,534,568	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	313,654		15
16	Equipment, at Historical Cost	151,371		16
17	Accumulated Depreciation (book methods)	(397,923)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deposits</u>	2,467		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 69,569	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,604,137	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 199,878	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	219,212		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,664		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	26,349		36
37	<u>Notes Payable - Related Parties</u>	550,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,006,103	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,006,103	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 598,034	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,604,137	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 982,883	1
2	Restatements (describe):		2
3		(13)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 982,870	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(384,836)	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (384,836)	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)	\$ 598,034	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,960,078	1
2	Discounts and Allowances for all Levels	(1,053,435)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,906,643	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,062,236	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,062,236	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	2,850	13
14	Non-Patient Meals	2,394	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,244	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,459	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,459	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	253	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 253	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,980,835	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,229,956	31
32	Health Care	3,010,858	32
33	General Administration	1,153,359	33
B. Capital Expense			
34	Ownership	901,983	34
C. Ancillary Expense			
35	Special Cost Centers	811,418	35
36	Provider Participation Fee	257,962	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,365,536	40
41	Income before Income Taxes (line 30 minus line 40)**	(384,701)	41
42	Income Taxes	(135)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (384,836)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,564,834	44
45	Private Pay - Net Inpatient Revenue	2,043,568	45
46	Medicare - Net Inpatient Revenue	834,666	46
47	Other-(specify) <u>Managed Care/Private Insurance</u>	463,575	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,906,643	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center

0032680

Report Period Beginning:

07/01/17

Ending:

06/30/18

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	1,994	2,150	\$ 72,936	\$ 33.92	1
2	Assistant Director of Nursing	1,930	2,082	66,742	32.06	2
3	Registered Nurses	12,918	13,930	409,349	29.39	3
4	Licensed Practical Nurses	32,740	35,305	798,213	22.61	4
5	CNAs & Orderlies	75,894	81,839	1,013,969	12.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,877	2,024	66,569	32.89	8
9	Activity Director					9
10	Activity Assistants	5,083	5,481	61,019	11.13	10
11	Social Service Workers	3,948	4,257	75,978	17.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,147	22,803	249,744	10.95	15
16	Dishwashers					16
17	Maintenance Workers	4,078	4,398	106,236	24.16	17
18	Housekeepers	17,051	18,387	194,105	10.56	18
19	Laundry	5,816	6,272	59,230	9.44	19
20	Administrator	1,934	2,086	93,636	44.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,358	14,404	226,937	15.76	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	2,602	2,805	32,376	11.54	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	202,370	218,223	\$ 3,527,039 *	\$ 16.16	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	Contract	\$ 9,838	1, 3	35
36	Medical Director	Contract	10,046	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	3,892	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	2,592	11, 3	44
45	Social Service Consultant	Contract	2,952	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 29,320		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	508	\$ 21,989	10, 3	50
51	Licensed Practical Nurses	2,036	71,471	10, 3	51
52	Certified Nurse Assistants/Aides	2,055	43,709	10, 3	52
53	TOTAL (lines 50 - 52)	4,599	\$ 137,169		53

SEE ACCOUNTANTS' PREPARATION REPORT

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	
Gail Kimmle	Administrator	0	\$ 93,636	Workers' Compensation Insurance	\$ 135,738	IDPH License Fee	\$	
				Unemployment Compensation Insurance	53,520	Advertising: Employee Recruitment	13,917	
				FICA Taxes	261,430	Health Care Worker Background Check (Indicate # of checks performed _____)	1,505	
				Employee Health Insurance	97,087	Patient Background Checks	1,820	
				Employee Meals		IHCA Allowable Fees	5,070	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	2,317	
				Employee Drug Tests	2,546			
				Uniforms	2,093			
				Employee Relations	890			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,636	TOTAL (agree to Schedule V, line 22, col.8)		\$ 553,304		
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
N/A			\$	Section N/A		\$	Out-of-State Travel	\$
							In-State Travel	3,160
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	1,493
C. Professional Services				TOTAL			\$	
Vendor/Payee	Type		Amount				Entertainment Expense	()
SJM & Co.	Accounting/Consulting		\$ 850				(agree to Sch. V, line 24, col. 8)	
C.J. Schlosser & Company	Accounting/Consulting		16,084				TOTAL	\$ 4,653
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 16,934					

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' PREPARATION REPORT

**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. IHCA \$5,070
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 61,200 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 257,962
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.

SEE ACCOUNTANTS' PREPARATION REPORT

- (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? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,394
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees