

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0051201</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Mercy Circle</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2019</u> to <u>06/30/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>3659 W 99th Street</u> <u>Chicago</u> <u>60655</u>																									
Number City Zip Code																									
County: <u>County</u>																									
Telephone Number: <u>(773) 253-3814</u> Fax # <u>(773) 779-6094</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Frances Lachowicz</u></td></tr><tr><td>(Title) <u>Executive Director</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Frances Lachowicz</u>	(Title) <u>Executive Director</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
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	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>05/06/2014</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501c3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501c3</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>: Pamela Latovick</u> Telephone Number: <u>(734) 343-6628</u>																									
Email Address: _____																									

Facility Name & ID Number Mercy Circle

0051201 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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 23

	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>23</u>	Skilled (SNF)	<u>23</u>	<u>8,418</u>	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	<u>23</u>	TOTALS	<u>23</u>	<u>8,418</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,459</u>	<u>2,254</u>	<u>2,466</u>	<u>8,179</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,459</u>	<u>2,254</u>	<u>2,466</u>	<u>8,179</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.16%

D. How many bed reserve days during this year were paid by the Department? 0 (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 23 and days of care provided 2,466

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ 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: 07/01/2019 Ending: 06/30/2020

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	461,375	61,730	349,880	872,985	13,524	886,509	(643,960)	242,549			1
2	Food Purchase		290,127		290,127		290,127	(208,178)	81,949			2
3	Housekeeping	163,867	33,320	433	197,620	3,575	201,195	(148,329)	52,866			3
4	Laundry			45,957	45,957		45,957	(30,019)	15,938			4
5	Heat and Other Utilities			226,971	226,971		226,971	(181,311)	45,660			5
6	Maintenance	267,110	25,729	310,532	603,371	7,731	611,102	(491,601)	119,501			6
7	Other (specify):*											7
8	TOTAL General Services	892,352	410,906	933,773	2,237,031	24,830	2,261,861	(1,703,398)	558,463			8
	B. Health Care and Programs											
9	Medical Director			32,404	32,404		32,404	(3,000)	29,404			9
10	Nursing and Medical Records	1,842,600	55,996	23,666	1,922,262	(27,764)	1,894,498	(666,519)	1,227,979			10
10a	Therapy											10a
11	Activities	130,559	5,951	8,933	145,443	3,202	148,645	(97,094)	51,551			11
12	Social Services	118,973		14	118,987	1,648	120,635	(30,932)	89,703			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,092,132	61,947	65,017	2,219,096	(22,914)	2,196,182	(797,545)	1,398,637			16
	C. General Administration											
17	Administrative	58,117			58,117	615	58,732	(35,007)	23,725			17
18	Directors Fees											18
19	Professional Services			800,302	800,302	(4,071)	796,231	(475,055)	321,176			19
20	Dues, Fees, Subscriptions & Promotions			332,669	332,669	(61,749)	270,920	(218,840)	52,080			20
21	Clerical & General Office Expenses	298,341	(2,139)	73,302	369,504	4,900	374,404	(225,459)	148,945			21
22	Employee Benefits & Payroll Taxes			838,017	838,017		838,017	(285,285)	552,732			22
23	Inservice Training & Education											23
24	Travel and Seminar			24,820	24,820	5,940	30,760	(18,334)	12,426			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,855	72,855		72,855	(43,425)	29,430			26
27	Other (specify):*			102,732	102,732		102,732	(102,732)				27
28	TOTAL General Administration	356,458	(2,139)	2,244,697	2,599,016	(54,365)	2,544,651	(1,404,137)	1,140,514			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,340,942	470,714	3,243,487	7,055,143	(52,449)	7,002,694	(3,905,080)	3,097,614			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			1,072,292	1,072,292		1,072,292	(871,613)	200,679			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,017,356	1,017,356		1,017,356	(838,573)	178,783			32
33	Real Estate Taxes			167,386	167,386		167,386	(139,215)	28,171			33
34	Rent-Facility & Grounds			120,000	120,000		120,000	(120,000)				34
35	Rent-Equipment & Vehicles			24,034	24,034	(3,100)	20,934	(17,284)	3,650			35
36	Other (specify):*											36
37	TOTAL Ownership			2,401,068	2,401,068	(3,100)	2,397,968	(1,986,685)	411,283			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			656,290	656,290		656,290		656,290			39
40	Barber and Beauty Shops			35,959	35,959		35,959		35,959			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					55,549	55,549		55,549			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			692,249	692,249	55,549	747,798		747,798			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,340,942	470,714	6,336,804	10,148,460		10,148,460	(5,891,765)	4,256,695			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,362)	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	(235)	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				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	17,268	27		24
25	Fund Raising, Advertising and Promotional	(143,732)	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)	\$ (140,061)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (140,061)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Garage Parking Fees	\$ (12,960)	6	1
2	Miscellaneous Revenue	(5,399)	21	2
3	Nursing Supplies/Briefs for AL/IL/Memory Care	152	10	3
4	Licenses/Taxes for AL/IL/Memory Care	2,860	20	4
5	Nursing Wages for AL/IL/Memory Care	(666,671)	10	5
6	Benefits for AL/IL/Memory Care	(51,357)	22	6
7	Physican Fees for AL/IL/Memory Care	(3,000)	9	7
8	Late Fee - Bed Tax	(159)	20	8
9	Miscellaneous - Postage, Jury Duty, Telephone	(286)	21	9
10	Mscellaneous - Catering Income	(14,444)	1	10
11	Miscellaneous - Maintenance	(4,120)	6	11
12	Unsupported Expense	(170)	35	12
13	Lobbying Portion of Dues	(962)	20	13
14	Marketing Expense	(1,146)	19	14
15	Contributions	(120,000)	27	15
16	Remove Dietary Expense allocated to AL/IL	(616,154)	1	16
17	Remove Housekeeping Expense allocated to AL/IL	(148,329)	3	17
18	Remove Laundry Expense allocated to AL/IL	(30,019)	4	18
19	Remove Utilities allocated to AL/IL	(181,311)	5	19
20	Remove Maintenance Expense allocated to AL/IL	(474,521)	6	20
21	Remove Activity Expense allocated to AL/IL	(97,094)	11	21
22	Remove Social Service Expense allocated to AL/IL	(30,932)	12	22
23	Remove Admin Expense allocated to AL/IL	(35,007)	17	23
24	Remove Professional Services allocated to AL/IL	(473,909)	19	24
25	Remove Miscellaneous Expense allocated to AL/IL	(76,847)	20	25
26	Remove Gen Office Expenses allocated to AL/IL	(219,774)	21	26
27	Remove Travel/Seminar Expense allocated to AL/IL	(18,334)	24	27
28	Remove Insurance Expnsne allocated to AL/IL	(43,425)	26	28
29	Remove Depreciation Expense allocated to AL/IL	(871,613)	30	29
30	Remove Interest Expense allocated to AL/IL	(838,338)	32	30
31	Remove Rental Expense allocated to AL/IL	(17,114)	35	31
32	Remove Benefits allocated to AL/IL	(233,928)	22	32
33	Remove Food allocated to AL/IL	(208,178)	2	33
34	Remove Real Estate Taxes allocated to AL/IL	(139,215)	33	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	(5,631,704)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Circle# 0051201

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

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	(643,960)	0	0	0	0	0	0	0	0	0	0	(643,960)	1
2	Food Purchase	(208,178)	0	0	0	0	0	0	0	0	0	0	(208,178)	2
3	Housekeeping	(148,329)	0	0	0	0	0	0	0	0	0	0	(148,329)	3
4	Laundry	(30,019)	0	0	0	0	0	0	0	0	0	0	(30,019)	4
5	Heat and Other Utilities	(181,311)	0	0	0	0	0	0	0	0	0	0	(181,311)	5
6	Maintenance	(491,601)	0	0	0	0	0	0	0	0	0	0	(491,601)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,703,398)	0	0	0	0	0	0	0	0	0	0	(1,703,398)	8
	B. Health Care and Programs													
9	Medical Director	(3,000)	0	0	0	0	0	0	0	0	0	0	(3,000)	9
10	Nursing and Medical Records	(666,519)	0	0	0	0	0	0	0	0	0	0	(666,519)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(97,094)	0	0	0	0	0	0	0	0	0	0	(97,094)	11
12	Social Services	(30,932)	0	0	0	0	0	0	0	0	0	0	(30,932)	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	(797,545)	0	0	0	0	0	0	0	0	0	0	(797,545)	16
	C. General Administration													
17	Administrative	(35,007)	0	0	0	0	0	0	0	0	0	0	(35,007)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(475,055)	0	0	0	0	0	0	0	0	0	0	(475,055)	19
20	Fees, Subscriptions & Promotions	(218,840)	0	0	0	0	0	0	0	0	0	0	(218,840)	20
21	Clerical & General Office Expenses	(225,459)	0	0	0	0	0	0	0	0	0	0	(225,459)	21
22	Employee Benefits & Payroll Taxes	(285,285)	0	0	0	0	0	0	0	0	0	0	(285,285)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(18,334)	0	0	0	0	0	0	0	0	0	0	(18,334)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(43,425)	0	0	0	0	0	0	0	0	0	0	(43,425)	26
27	Other (specify):*	(102,732)	0	0	0	0	0	0	0	0	0	0	(102,732)	27
28	TOTAL General Administration	(1,404,137)	0	0	0	0	0	0	0	0	0	0	(1,404,137)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,905,080)	0	0	0	0	0	0	0	0	0	0	(3,905,080)	29

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.						
Michael Davis	BOD					
John Eber	BOD					
Margaret Mary Hinz, RSM	BOD					
Margaret Johnson, RSM	BOD					
Kevin Connelly	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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Land Lease	\$ 120,000	Sisters of Mercy of the Americas West Midwest Comm., Inc.	100.00%	\$	\$ (120,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 120,000			\$	\$ * (120,000)	14

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

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	Marion Cypser, RSM	BOD						1
2	Jean Okroi, RSM	BOD						2
3	Frances Lachowicz	BOD						3
4	Ann Flanagan, RSM	BOD						4
5	Darlene O'Callaghan	BOD						5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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:

07/01/2019Ending: 6/30/2020

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First National Bank		X	Constuction of Facility			\$ 26,250,000	\$ 17,738,707		0.0340	\$ 886,426	1	
2	West Midwest FIDES	X					15,814,000	13,601,641		0.0325	130,930	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 42,064,000	\$ 31,340,348			\$ 1,017,356	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 42,064,000	\$ 31,340,348			\$ 1,017,356	15	

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

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

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mercy Circle COUNTY County
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 2019 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 2019.

(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>24-11-300-022-0000</u>	<u></u>	\$ <u>211,078.60</u>	\$ <u>35,524.22</u>
2. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u><u>211,078.60</u></u>	\$ <u><u>35,524.22</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? X 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

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:

1		2		3		4	
A. Land.		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	23			2014	\$ 6,537,662	\$ 163,442	40	\$ 163,442	\$	\$ 1,089,610
5										
6										
7										
8										
	Improvement Type**									
9	Aluminum Logo Sign		2015	631	63	10	63			373
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Mercy Circle

0051201

Report Period Beginning:

07/01/2019 Ending: 06/30/2020

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	First Security System - Key pads for Memory Care (AL)	2017	\$ 1,370	\$ 274	5	\$ 274	\$	\$ 959	37
38	Key Carpet - in AL	2017	1,525	153	10	153		521	38
39	SNF Security System - Upgrade - Skilled NF only	2017	5,274	527	10	527		2,022	39
40	First Security System - in AL/IL, not Skilled NF	2018	37,106	3,711	10	3,711		8,967	40
41	First Security Syatem - in Skilled NF only	2018	1,920	384	5	384		864	41
42	HVAC Unit - applicable to Skilled NF only	2018	4,015	402	10	402		903	42
43	Linear Electric - applicable to Skilled NF only	2018	2,350	470	5	470		1,058	43
44	Complete Electric - applicable to Skilled NF only	2018	2,650	530	5	530		1,546	44
45	Dining Equipment - applicable to Skilled NF and AL	2019	13,636	1,364	10	1,364		1,477	45
46	Security Cameras - front of building, all areas.	2019	3,960	396	10	396		429	46
47	Hand Wash Sink - applicable to AL/IL	2019	6,260	626	10	626		678	47
48	Undercounter Dishwasher - applicable to AL	2020	6,121	510	10	510		510	48
49	Camera in Kitchen - applicable to whole facility	2020	5,725	477	10	477		477	49
50	Security Nurse Guard/Roam Alert applicable to Skilled NF/AL	2020	3,045	254	10	254		254	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)		\$ 6,633,250	\$ 173,583		\$ 173,583	\$	\$ 1,110,648	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$390,445	\$36,965	\$36,965	\$	5/7/2010	\$263,007	71
72	Current Year Purchases	2,508	209	209		10	209	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$392,953	\$37,174	\$37,174	\$		\$263,216	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	\$	\$	\$		\$55,317	76
77	Utility Truck-Maintenance	Dodge Ram Truck, 2013	2014	26,033					26,033	77
78	Car - Resident Transport	Toyota Camry, 2010	2014	14,344					14,344	78
79	Car - Resident Transport	Toyota Avalon, 2007	2014	12,171					12,171	79
80	TOTALS			\$107,865	\$	\$	\$		\$107,865	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)	\$7,134,068	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$210,757	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$210,757	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)	\$1,481,729	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	\$5,384,661	86
87	Aluminum Logo Sign, 2015	3,119	312	1,845	87
88	Equipment, Prior Years	683,957	62,565	450,594	88
89	Equipment, Current Year	12,383	1,032	1,032	89
90					90
91	TOTALS	\$33,007,424	\$871,608	\$5,838,132	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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: \$ 20,764
- Description: Copier, 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

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. /2021 \$
13. /2022 \$
14. /2023 \$

* 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.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 262,097	\$ 50		\$ 262,147	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			38,802	312		39,114	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			266,221	6,915		273,136	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 prescrpts			52,618			52,618	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Med Spl/Oxygen</u>	39-3				7,888			7,888	12
13	Other (specify): <u>Lab/Xray</u>	39-3				21,387			21,387	13
14	TOTAL			\$		\$ 649,013	\$ 7,277		\$ 656,290	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.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,273,168	\$	1
2	Cash-Patient Deposits	16,867		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (21,641))	282,576		3
4	Supply Inventory (priced at)	54,788		4
5	Short-Term Investments			5
6	Prepaid Insurance	13,128		6
7	Other Prepaid Expenses	7,932		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,648,459	\$	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	1,197,157		16
17	Accumulated Depreciation (book methods)	(7,299,202)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,176,369		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(380,466)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: Land Lease	1,727,596		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 36,270,831	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 38,919,290	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,209,504	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	347,652		28
29	Short-Term Notes Payable	1,242,743		29
30	Accrued Salaries Payable	290,595		30
31	Accrued Taxes Payable (excluding real estate taxes)	113		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,000		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)	\$ 7,129,607	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	13,601,641		40
41	Bonds Payable	17,208,581		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Restricted Assets/Donations	1,806,963		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 32,617,185	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 39,746,792	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (827,502)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 38,919,290	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (997,043)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (997,043)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(849,144)	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	1,018,685	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 169,541	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)	\$ (827,502)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mercy Circle

0051201

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

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	\$ 7,975,345	1
2	Discounts and Allowances for all Levels	12,939	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,988,284	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	365,353	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 365,353	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	32,007	13
14	Non-Patient Meals	27,806	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	12,960	16
17	Sale of Drugs	81,143	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,532	19
20	Radiology and X-Ray	6,280	20
21	Other Medical Services	66,248	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 243,976	23
	D. Non-Operating Revenue		
24	Contributions	605,358	24
25	Interest and Other Investment Income***	235	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 605,593	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Federal Financial Awards (CARES ACT Funds)	96,110	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 96,110	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,299,316	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,237,031	31
32	Health Care	2,222,561	32
33	General Administration	2,599,016	33
	B. Capital Expense		
34	Ownership	2,401,068	34
	C. Ancillary Expense		
35	Special Cost Centers	688,784	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)*	\$ 10,148,460	40
41	Income before Income Taxes (line 30 minus line 40)**	(849,144)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (849,144)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 652,043	44
45	Private Pay - Net Inpatient Revenue	812,061	45
46	Medicare - Net Inpatient Revenue	1,381,207	46
47	Other-(specify)		47
48	Other-(specify) <u>Assisted/Independent Living</u>	5,142,973	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,988,284	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.

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	1,920	2,080	\$ 107,922	\$ 51.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,048	14,063	444,698	31.62	3
4	Licensed Practical Nurses	9,098	10,229	307,826	30.09	4
5	CNAs & Orderlies	50,774	59,105	940,284	15.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,560	1,835	36,611	19.95	9
10	Activity Assistants	5,051	5,808	93,948	16.18	10
11	Social Service Workers	3,638	3,953	118,973	30.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,512	6,227	100,362	16.12	14
15	Cook Helpers/Assistants	24,098	27,036	361,013	13.35	15
16	Dishwashers					16
17	Maintenance Workers	9,605	10,799	267,110	24.73	17
18	Housekeepers	9,083	10,329	163,867	15.86	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	3,026	3,345	120,640	36.07	22
23	Office Manager	1,842	2,080	66,552	32.00	23
24	Clerical	8,038	8,824	169,266	19.18	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	2,183	2,430	41,870	17.23	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,476	168,143	\$ 3,340,942 *	\$ 19.87	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	576	28,440	9/3	36
37	Medical Records Consultant	41	1,345	10/3	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	15	954	11/3	44
45	Social Service Consultant	7	492	12/3	45
46	Other(specify) Security	4,801	87,976	19/3	46
47	MDS Coordinator	22	1,933	10/3	47
48					48
49	TOTAL (lines 35 - 48)	5,462	\$ 121,140		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

STATE OF ILLINOIS

Facility Name & ID Number

Mercy Circle

0051201

Report Period Beginning:

07/01/2019

Page 21

Ending: 06/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Tirpak	HR Manager	0	\$ 58,732
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,732

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
Point Click Care	Billing Software	\$ 23,434
Trinity Senior Living Communities	Mgt Fees/Travel/Consult	414,495
Corporation Service Company	Lgl Svcs - Statutory Repres.	118
Plante & Moran, PLLC	Financial Statement Review	24,000
Trinity Senior Living Communities	Adm. Salary/Benefits	180,026
Sisters of Mercy - Americas	Office 365 Bus Essentials	4,373
Access Media 3	Direct TV	52,234
PathwayHealth	Retainer Fee	17,800
Shred-It	Shredding	3,212
Flamm&Teibl/JacksonLewis/Polsin	Legal Services	40,895
PathwayHealth/Linda K. Smith	Interim Consultants	4,102
Misc. Other Expense	See Attached	35,613
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 800,302

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 61,116
Unemployment Compensation Insurance	355
FICA Taxes	191,614
Employee Health Insurance	398,342
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	28,616
403B Employer Match	88,224
Employee Appreciation	18,393
Expense allocated to AL/IL	(233,928)
TOTAL (agree to Schedule V, line 22, col.8)	\$ 552,732

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

Description	Line #	Amount
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	45,411
Health Care Worker Background Check (Indicate # of checks performed 9)	200
Patient Background Checks	
Dues & Subscriptions	10,018
Licenses & Taxes	4,417
Bank/Trust Acct/Letter of Credit Fees	68,881
Dues/Fees allocated to AL/IL	(76,847)
Less: Public Relations Expense	(
Non-allowable advertising	(
Yellow page advertising	(
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 52,080

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
Trinity Senior Living Comm. Travel	2,843
Travel to Conferences	1,517
In-State Travel	
Miscellaneous Travel	790
Interim Consultants Travel	976
Travel/Seminar Exp allocated to AL/IL	(18,334)
Seminar Expense	
Admin - Conferences	15,107
First Nat'l Bank - Seminar Expense	9,527
Entertainment Expense	(
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 12,426

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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. LeadingAge \$6,414
- (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? Yes
What was the average life used for new equipment added during this period? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,978 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. \$ 55,549
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. \$ 13,362
- (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. \$ _____
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
Additional Support
FYE 6-30-20

Professional Services	
Trinity Health Senior Communities	408,367 Management Fees
MDI Achieve	1,500 Clinical Software
Pointclick Care Tech.	23,434 PCC - Billing/Clinical Software
Plante and Moran	11,000 Accounting Services, review of Financial Statements final Bill
Polisnelli, PC	9,396 Legal Counsel, theft, survey
Flamm & Teibloom PC	13,836 Legal Services, Real Estate matters, Non Prof Exempt/Prop Assess.
Pathway Health	2,758 Interim MDS r/c to line 10, travel to line 24
Jackson Lewis, PC	7,498 Legal services, empl/resident matters
Kopon Airdo LLC	10,165 Legal Services, workplace violence, etc.
Trinity Sr. Living Communities	180,026 Administrator salary and benefits
NRC	1,179 Resident Satisfaction Survey
THSC - expenses	2,843 Travel - r/c to line 21
THSC - expenses	2,139 Clinical Software - SimpleTC, Matrixcare
THSC - expenses	1,146 Marketing Software - Enquire, remove as nonallowable
Access Media 3, Inc.	52,224 HD Direct TV Programming
Sisters of Mercy Americas	13,000 Plante & Moran Audit Interim bill
Sisters of Mercy Americas	4,373 Office 365 Business Essentials
Pathway Health	17,800 Retainer Fee
DBScott Consulting	2,272 Training/Seminar - r/c to line 24
Smith, Linda K.	1,345 Medical Records Consulting, r/c to line 10
Shred-it USA LLC	3,212 Shredding Services
First Nat'l Bank	165
Accruals	28,325 includes \$48,000 of accrual removed from c/r in FY19.
Corporation Service Comp.	118 Statutory Representation
Miscellaneous Minor Vendors	2,171
Total Professional Services Exp.	800,301

Dues, Fees & Subscriptions	
IL State Police Backgr Chks	200
Sales & Marketing	149,932 (149,932)
Adv./Empl Recruit	45,411
Dues & Subscriptions	10,980 (962) 10,018
IDPH License Fee	-
Licenses & Fees	60,125 (55,708) 4,417
Bank/Trust Act/LOC	68,881
AL/IL Licenses & Fees	(2,860) 2,860 -
	332,669 (203,742) 128,926
Allocated to AL/IL	(76,846) (76,846)
Net	332,669 (280,588) 52,080

Leased Equipment	
Canon Finan Svcs	23 Graphic Equipment
Pitney Bowes Global	851 Postage Meter
Proven Business Solutions	4,390 Maintenance of Copiers, reclass to line 6
TIAA Commercial Finance	2,614 Equipment
TIAA Commercial Finance	237 Reclass from Line 6, Maintenance
Xerox Financial Services	16,445 Copiers
First National Bank Omaha	42
Accrual	170 Remove, unsupported
Pitney Bowes Global	1,053 Reclass from Line 21, Postage
Total	25,424

Adjusted Leased Equip., L. 35 20,764

Employee Benefits Line 22	
Employee Benefits/Payroll Tax/Col. 3	Col. 7 Adjusted
Workers Compensation	61,116
Unemployment Comp.	355
FICA Taxes	238,617 (47,002) 191,614
Employee Health Insurance	402,696 (4,354) 398,341
Employee Life Insurance	28,616
Employee Pension	-
A03B Employer Match	88,224
Employee Appreciation	18,393 - 18,393
Subtotal	838,017 (51,357) 786,660
Indirect allocation to AL/IL	- (233,928) (233,928)
Total	838,017 (285,285) 552,732

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

Travel	
Petty Cash	132 Admin Parking for local travel
First Nat'l Bank Omaha	830 Admin Travel for conferences
First Nat'l Bank Omaha	598 N Admin Travel for conferences
First Nat'l Bank Omaha	229 S Svcs Travel for conferences
Misc	- Maintenance Reclass
Payroll	448 N Admin Reimb for local travel
Payroll	35 Maintenance Reimb for local travel
Payroll	35 Hkpg Reimb for local travel
Pathway Health	976 Admin Travel for temp DON, MDS Coord.
TSLC - out of State	2,843 Admin Travel of TSLC employees to Mercy Circle
Total Travel	6,126

Training/Seminars	
First Nat'l Bank/Srs Mercy	1,095 Admin Misc. Training
DBScott Consulting LLC	2,272 Admin Training
Lee A Moriarty	550 Activities Training-Alz Unit & Activity Dir Course
First Nat'l Bank Omaha	412 Activities Applied Research on Dementia/Natl Council of Cert Dementia Practitioners
First Nat'l Bank Omaha	125 Admin Applied Research on Dementia
First Nat'l Bank Omaha	1,512 Admin HIN (Health Info Network) 2 seminars online/Leading Age/IL Cont of Care Assoc.
First Nat'l Bank Omaha	1,058 N Admin HIN (Health Info Network)
First Nat'l Bank Omaha	572 Admin Leading Age/IL Cont of Care Assoc.
First Nat'l Bank Omaha	199 Admin Compliance webinar
First Nat'l Bank Omaha	1,210 Admin Leading Age Seminars
First Nat'l Bank Omaha	1,497 Admin Seminar - Pathway Health, Leading Age
First Nat'l Bank Omaha	Admin Leading Age Webinar Subscription
First Nat'l Bank Omaha	189 Admin Society for Human Resources
First Nat'l Bank Omaha	232 Admin eFoodcard-online training food safety
First Nat'l Bank Omaha	85 Admin Training Publications
First Nat'l Bank Omaha	150 Admin ECIS Solutions
Sisters of Mercy-Americas	1,035 Admin Mercy Network on Aging conference - 3 attendees
Saint Xavier University	11,250 N Admin Gerontology courses - 4 Nurses
First Nat'l Bank Omaha	618 N Admin AANAC
First Nat'l Bank Omaha	375 N Admin Online/in-person seminars
First Nat'l Bank Omaha	124 N Admin Meals during conferences
First Nat'l Bank Omaha	8 Admin Snacks for meeting
First Nat'l Bank Omaha	25 N Admin Snacks for meeting
Total Training/Seminars	24,633

Mercy Circle
Consultants
FYE 6-30-20

Activities			Act	SS
8/31/2019 Socialwork Consultation Group	6	368	6	368
10/31/2019 Socialwork Consultation Group	4	228		4 228
1/31/2020	4	256	4	256
3/31/2020	4	264		4 264
5/31/2020	1	66	1	66
6/30/2020	4	264		4 264
Total	22	1,446	15	954 8 492

Socialwork Consultation Group provided Activities and Social Services consulting, all expense put to Activities. Portion applicable to Social Services to b reclassified.

Maintenance Date	Hours	\$	
7/31/2018 Excel Security Services, Inc.	84	1,408	6/17-6/24
	84	1,408	6/24-7/1/19
	84	1,508	7/1-7/8/19
	84	1,492	7/8-7/15
	84	1,492	7/15-7/22
	84	1,492	7/22-7/29
8/31/2018	84	1,492	7/29-8/5
	84	1,492	8/5-8/12
	84	1,492	8/12-8/19
	85	1,510	8/19-8/26
9/30/2018	84	1,563	8/26-9/2
	84	1,527	9/2-9/9
	84	1,492	9/9-9/16
	84	1,492	9/16-9/23
10/31/2018	84	1,492	9/30-10/7
	84	1,492	10/7-10/14
	84	1,492	10/14-10/21
	84	1,492	10/21-10/28
11/30/2018	84	1,492	10/28-11/4
	84	1,563	11/4-11/11
	84	1,527	11/11-11-18
	84	1,492	11/18-11/25
	86	1,705	
12/31/2018	84	1,492	12/2-12/9
	84	1,492	12/16-12/23
	84	1,598	12/23-12/30
	84	1,598	12/30-1/6
1/31/2019	84	1,492	1/6-1/13
	84	1,492	1/13-1/20
	84	1,492	1/20-1/27
	84	1,492	1/27-2/3
2/28/2019	86	1,510	
	84	1,492	2/3-2/10
	84	1,492	2/10-2/17
	84	1,492	2/17-2/24
	84	1,492	2/24-3/2
3/31/2019	84	1,492	3/2-3/9
	95	1,772	3/9-3/16
	84	1,492	3/16-3/23
4/30/2019	84	1,492	3/23-3/30
	84	1,492	3/31-4/6
	84	1,492	4/6-4/13
	84	1,598	4/13-4/20
	84	1,492	4/20-4/27
	84	1,492	4/27-5/4
5/31/2019	84	1,492	5/4-5/11
	168	3,045	5/11-5/18
	168	3,045	5/18-5/25
6/30/2019	168	3,263	5/25-6/1
	168	3,045	6/1-6/8
	166	2,999	6/8-6/15
	168	3,045	6/15-6/22
Total Maintenance	4,801	87,976	

Pathway Health		MDS	Travel
9/30/2019 Pathway Health	493	6 493	
9/30/2019	2,265	16 1,440	825
2/28/2020 Retainer Fee	17,800		
	20,558	22 1,933	825

Smith, Linda Medical Records Consultant		
7/31/2019	6	198
8/31/2019	5	149
12/31/2019	5	165
1/31/2020	11	371
1/31/2020	6	182
1/31/2020	3	83
2/29/2020	6	198
Total	41	1,345 Line 10

Medical Director		
7/31/2019 Little Co of Mary	48	2,370
8/31/2019	48	2,370
9/30/2019	48	2,370
10/31/2019	48	2,370
11/30/2019	48	2,370
12/31/2019	48	2,370
1/31/2020 OSF Multi-Specialty Group	48	2,370
2/28/2020	48	2,370
3/31/2020	48	2,370
4/30/2020	48	2,370
5/31/2020	48	2,370
6/30/2020	48	2,370
	576	28,440 Line 9

Little Company of Mary changed name to OSF Multi-Specialty Group effective 1/1/2020.

Direct Expense for AL/IL and MC		
Description	Amount	Line #
Supplies/Briefs	152	10
Licenses/Fees	2,860	20
Nursing Wages	(645,483)	10
Nursing Wages COVID	(21,188)	10 (allocation)
Benefits	(51,357)	22
Physician Fees	<u>(3,000)</u>	9
Total	(718,015)	

Line #	1	2	3	4	5	6	11	12	17	19	20	21	24	26	30	32	33	35	
Cost Center	Dietary	Food	Housekpg	Laundry	Utilities	Maintenance	Activities	Soc. Svcs.	Admin	Prof Svcs	Misc.	Gen Office	Trav/Sem	Insurance	Depreciation	Interest	Real Est Tax	Rent Equip	Total
Direct Expense	858,703	290,127	201,195	45,957	226,971	594,022	148,645	120,635	58,732	795,085	128,927	368,719	30,760	72,855	1,072,292	1,017,121	167,386	20,764	6,218,896
Benefits	108,636	-	38,584	-	-	62,894	30,741	28,013	13,684	-	-	70,248	-	-	-	-	-	-	352,800
Total Expense to Allocate	967,339	290,127	239,779	45,957	226,971	656,916	179,386	148,648	72,416	795,085	128,927	438,967	30,760	72,855	1,072,292	1,017,121	167,386	20,764	6,571,696

Direct Expense																			
AL	456,837	154,350	65,788	30,019	56,821	148,710	97,094	18,559	24,177	327,298	53,073	151,784	12,662	29,991	-	-	62,409	-	1,689,573
IL	159,317	53,828	82,541	-	124,490	325,811	-	12,373	10,830	146,611	23,774	67,991	5,672	13,434	871,613	838,338	76,806	17,114	2,830,543
SNF	242,549	81,949	52,866	15,938	45,660	119,501	51,551	89,703	23,725	321,176	52,080	148,945	12,426	29,430	200,679	178,783	28,171	3,650	1,698,780
Total	858,703	290,127	201,195	45,957	226,971	594,022	148,645	120,635	58,732	795,085	128,927	368,719	30,760	72,855	1,072,292	1,017,121	167,386	20,764	6,218,896

Benefits																			
AL	57,795		12,617			15,745	20,080	4,310	5,633			28,918							145,097
IL	20,155		15,829			34,496	-	2,873	2,523			12,953							88,831
SNF	30,685		10,138			12,652	10,661	20,831	5,528			28,377							118,872
Total	108,636		38,584			62,894	30,741	28,013	13,684			70,248							352,800

Statistic	Meals		Adj Sq Ftge	Patient Days	Sq Footage	Sq Footage	Patient Days	Discharges	Accum Cost	Accum Cost	Accum Cost	Accum Cost	Accum Cost	Accum Cost	Depr Exp	Bldg Cost	Sq Ftge	Bldg Cost
AL	46,215	46,215	30,160	15,405	30,160	30,160	15,405	12	1,856,741	1,856,741	1,856,741	1,856,741	1,856,741	1,856,741			53,692	
IL	16,117	16,117	37,840	-	66,078	66,078	-	8	831,714	831,714	831,714	831,714	831,714	831,714	871,608	33,007,423	66,078	33,007,423
SNF	24,537	24,537	24,236	8,179	24,236	24,236	8,179	58	1,822,009	1,822,009	1,822,009	1,822,009	1,822,009	1,822,009	200,678	7,039,112	24,236	7,039,112
Total	86,869	86,869	92,236	23,584	120,474	120,474	23,584	78	4,510,463	4,510,463	4,510,463	4,510,463	4,510,463	4,510,463	1,072,286	40,046,535	144,006	40,046,535
	28.25%	28.25%	26.28%	34.68%	20.12%	20.12%	34.68%	74.36%	40.40%	40.40%	40.40%	40.40%	40.40%	40.40%	18.71%	17.58%	16.83%	17.58%

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.

Wages	461375	163867			267110	130559	118973	58117			298341							1498342	1842600	3340942
Benefits	108635.6056	38584.2119	0	0	62893.86425	30741.4924	28013.447	13684.26007	0	0	70247.5323	0	0	0	0	0	0	352800.4131	433859.5869	786660

<u>Description</u>	<u>Amount</u>	<u>Line #</u>	
Meal Income	(13,362)	1	Administrative/LTC only
Garage/Parking Fees	(12,960)	6	
Miscellaneous Revenue	(5,399)	21	
Postage/Jury Duty/Tel	(286)	21	
Catering Income	(14,444)	1	Revenue Offsets
Maintenance Misc Rev	(4,120)	6	
Interest Income	(235)	32	
Bad Debt Expense	17,268	27	F/S Expense Offsets
Lobbying Portion of Dues	(962)	20	
Marketing Expense	(143,732)	20	
	(1,146)	19	
Fines & Penalties	-	20	
Unsupported Expense	(170)	35	
		19	
Late Fee - Bed Tax	(159)	20	
Contributions	(120,000)	27	
Provider Participation Fee	55,549	42	Reclasses of expense
	(55,549)	20	
Social Services	492	12	
Activities	(492)	11	
Maintenance Expense	4,153	6	
Telephone/Doc Fee/Postage	(1,053)	19	
Copier	(3,100)	35	
Medical Records Consulting	1,345	10	
	(1,345)	19	
Interim MDS/DON	2,758	10	
Travel Expense	825	24	
Travel Expense	(825)	10	
Professional Services	(2,758)	19	
TSLC Travel	2,843	24	
Professional Services	(2,843)	19	
Training	2,272	24	
Professional Services	(2,272)	19	
Marketing - Legal Expense	(2,600)	20	
Professional Services	2,600	19	

Mercy Circle
Taxes
FYE 6/30/20

Tax Assessed for 2019 211,078.60

Mercy Circle Allocation

Area	Sq Ftge	% split	Tax Assessed
SNF	24,236	16.83%	35,524.22
AL	53,692	37.28%	78,699.72
IL	<u>66,078</u>	<u>45.89%</u>	<u>96,854.66</u>
Total	144,006	100.00%	211,078.60