

		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>8049116</u>			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Mercy Harvard Hospital Care</u>			I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2019</u> to <u>6/30/2020</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>901 S Grant PO 850</u> <u>Harvard</u> <u>60033</u>																																																		
Number City Zip Code																																																		
County: <u>McHenry</u>																																																		
Telephone Number: <u>608 755-5632</u> Fax # <u>608-741-7368</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) _____</td></tr><tr><td>(Title) _____</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) () Fax # ()</td></tr></table>			Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) () Fax # ()																																			
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	(Print Name and Title) _____																																																	
	(Firm Name & Address) _____																																																	
	(Telephone) () Fax # ()																																																	
Date of Initial License for Current Owners: <u>1954</u>																																																		
Type of Ownership:																																																		
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>			☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	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>Kallie James</u>																																																		
Telephone Number: <u>608-755-5362 ext 2082</u> Email Address: _____																																																		

Facility Name & ID Number Mercy Harvard Hospital Care

8049116 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 45

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>45</u>	Skilled (SNF)	<u>45</u>	<u>16,470</u>
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	<u>45</u>	TOTALS	<u>45</u>	<u>16,470</u>

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>1,114</u>	<u>4,637</u>	<u>2,011</u>	<u>7,762</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>1,114</u>	<u>4,637</u>	<u>2,011</u>	<u>7,762</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.13%

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)
Meals on wheels, Employee Meals

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 1976

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date Mar, 2003 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 34 and days of care provided 1,814

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2020 Fiscal Year: 6/30/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2019 Ending: 6/30/2020
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	426,920	26,788	123,834	577,542	(1,646)	575,896	(72,295)	503,601			1
2	Food Purchase											2
3	Housekeeping	213,877	31,773	60,810	306,460	(4,496)	301,964	(253,697)	48,267			3
4	Laundry		1,356	3,027	4,383		4,383	(3,150)	1,233			4
5	Heat and Other Utilities					275,607	275,607	(231,552)	44,055			5
6	Maintenance		67	679,627	679,694	(278,159)	401,535	(337,352)	64,183			6
7	Other (specify):* SPD & Light Duty	96,365	2,287	6,353	105,005	(17)	104,988	(13,179)	91,809			7
8	TOTAL General Services	737,162	62,271	873,651	1,673,084	(8,711)	1,664,373	(911,225)	753,148			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	6,549,604	1,586,172	3,064,512	11,200,288	(7,940,813)	3,259,475	(149,712)	3,109,763			10
10a	Therapy	413,738	16,073	45,940	475,751	(52,710)	423,041	(53,107)	369,934			10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Covid related	1,732,193	287,668	2,666,184	4,686,045	(4,435,593)	250,452	(135,000)	115,452			15
16	TOTAL Health Care and Programs	8,695,535	1,889,913	5,776,636	16,362,084	(12,429,116)	3,932,968	(337,819)	3,595,149			16
	C. General Administration											
17	Administrative	64,754	934	1,232,520	1,298,208	(113,681)	1,184,527	(926,802)	257,725			17
18	Directors Fees											18
19	Professional Services					21,915	21,915	(10,582)	11,333			19
20	Dues, Fees, Subscriptions & Promotions					54,541	54,541	(26,335)	28,206			20
21	Clerical & General Office Expenses	241,697	2,205	634,112	878,014	1,132	879,146	(353,155)	525,991			21
22	Employee Benefits & Payroll Taxes			2,444,141	2,444,141	(396,041)	2,048,100	(1,707,150)	340,950			22
23	Inservice Training & Education											23
24	Travel and Seminar					39,524	39,524	(19,084)	20,440			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			109,355	109,355	166,180	275,535	(133,041)	142,494			26
27	Other (specify):* Mktg, HR, Volunteers	5,572	767	267,326	273,665	(2,991)	270,674	(225,614)	45,060			27
28	TOTAL General Administration	312,023	3,906	4,687,454	5,003,383	(229,421)	4,773,962	(3,401,763)	1,372,199			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,744,720	1,956,090	11,337,741	23,038,551	(12,667,248)	10,371,303	(4,650,807)	5,720,496			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			1,566,848	1,566,848		1,566,848	(1,525,844)	41,004			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			284,199	284,199		284,199	(284,199)				32
33	Real Estate Taxes					57,314	57,314	(57,314)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					3,562	3,562	(2,219)	1,343			35
36	Other (specify):*											36
37	TOTAL Ownership			1,851,047	1,851,047	60,876	1,911,923	(1,869,576)	42,347			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					12,549,185	12,549,185	(12,549,185)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					57,187	57,187		57,187			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					12,606,372	12,606,372	(12,549,185)	57,187			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	9,744,720	1,956,090	13,188,788	24,889,598		24,889,598	(19,069,568)	5,820,030			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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(284,199)			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				24
25	Fund Raising, Advertising and Promotional				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)	\$ (284,199)		\$	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))	\$ (284,199)		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			see schedule	15	42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule			see shchedule	10,15,22	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Dietary Expense not related to SNF Care	\$ (72,295)	1	1
2	Housekeeping Expenses not related to SNF Care	(253,697)	3	2
3	Laundry Expenses not related to SNF Care	(3,150)	4	3
4	Heat & Other Utilities not related to SNF Care	(231,553)	5	4
5	Maintenance Expenses not related to SNF Care	(337,352)	6	5
6	Central Supply Expense not related to SNF Care	(13,180)	7	6
7	Nursing & Medical Records Exp not related to SNF	(149,712)	10	7
8	Therapy Expenses not related to SNF Care	(53,107)	10a	8
9	Administrative Expenses not related to SNF Care	(926,802)	17	9
10	Professional Services not related to SNF Care	(10,582)	19	10
11	Dues, Fees & Subscriptions not related to SNF	(26,335)	20	11
12	Clerical & General Office Exp not related to SNF	(353,156)	21	12
13	Employee Ben & Payroll Taxes not related to SNF	(1,707,150)	22	13
14	Travel & Seminar Expense not related to SNF	(19,084)	24	14
15	Insurance Expenses not related to SNF Care	(133,041)	26	15
16	Human Res & Marketing Exp not related to SNF	(225,614)	27	16
17	Depreciation Expense not related to SNF Care	(1,525,844)	30	17
18	Interest Expense not related to SNF Care	(284,199)	32	18
19	Real Estate Taxes not related to SNF Care	(57,314)	33	19
20	Rent Expense - Equipment not related to SNF Care	(2,219)	35	20
21	Ancillary Services related to Acute - not SNF Oper	(12,549,186)	39	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	(18,934,568)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Harvard Hospital Care# 8049116

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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	(72,295)	0	0	0	0	0	0	0	0	0	0	(72,295)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(253,697)	0	0	0	0	0	0	0	0	0	0	(253,697)	3
4	Laundry	(3,150)	0	0	0	0	0	0	0	0	0	0	(3,150)	4
5	Heat and Other Utilities	(231,553)	0	0	0	0	0	0	0	0	0	0	(231,553)	5
6	Maintenance	(337,352)	0	0	0	0	0	0	0	0	0	0	(337,352)	6
7	Other (specify):*	(13,180)	0	0	0	0	0	0	0	0	0	0	(13,180)	7
8	TOTAL General Services	(911,226)	0	0	0	0	0	0	0	0	0	0	(911,226)	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	(149,712)	0	0	0	0	0	0	0	0	0	0	(149,712)	10
10a	Therapy	(53,107)	0	0	0	0	0	0	0	0	0	0	(53,107)	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	(202,818)	0	0	0	0	0	0	0	0	0	0	(202,818)	16
	C. General Administration													
17	Administrative	(926,802)	0	0	0	0	0	0	0	0	0	0	(926,802)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,582)	0	0	0	0	0	0	0	0	0	0	(10,582)	19
20	Fees, Subscriptions & Promotions	(26,335)	0	0	0	0	0	0	0	0	0	0	(26,335)	20
21	Clerical & General Office Expenses	(353,156)	0	0	0	0	0	0	0	0	0	0	(353,156)	21
22	Employee Benefits & Payroll Taxes	(1,707,150)	0	0	0	0	0	0	0	0	0	0	(1,707,150)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(19,084)	0	0	0	0	0	0	0	0	0	0	(19,084)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(133,041)	0	0	0	0	0	0	0	0	0	0	(133,041)	26
27	Other (specify):*	(225,614)	0	0	0	0	0	0	0	0	0	0	(225,614)	27
28	TOTAL General Administration	(3,401,762)	0	0	0	0	0	0	0	0	0	0	(3,401,762)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,515,806)	0	0	0	0	0	0	0	0	0	0	(4,515,806)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(1,525,844)	0	0	0	0	0	0	0	0	0	0	(1,525,844)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(284,199)	0	0	0	0	0	0	0	0	0	0	(284,199)	32
33	Real Estate Taxes	(57,314)	0	0	0	0	0	0	0	0	0	0	(57,314)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(2,219)	0	0	0	0	0	0	0	0	0	0	(2,219)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,869,577)	0	0	0	0	0	0	0	0	0	0	(1,869,577)	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	(12,549,186)	0	0	0	0	0	0	0	0	0	0	(12,549,186)	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	(12,549,186)	0	0	0	0	0	0	0	0	0	0	(12,549,186)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(18,934,568)	0	0	0	0	0	0	0	0	0	0	(18,934,568)	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
Mercy Health	100			Mercy Hospital	Janesville	Hospital
				Mercy Home Health	Janesville	Includes Homecare
				Mercy Health		Parent
				Mercy Walworth	Janesville	Hospital
				Javon Bea Hospital(s)	Rockford	Hospital

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			\$	n/a		\$	\$	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			\$			\$	\$ *	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								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

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 Harvard Hospital Care# 8049116 Report Period Beginning: 7/1/2019 Ending: 5/30/2020

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 Mercy Health
 Street Address 1000 Mineral Point
 City / State / Zip Code Janesville, WI 53545
 Phone Number (608-755-5362
 Fax Number (608-741-7368

	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	6	Maintenance	Hours Paid	42,945	3	\$ 1,231,152	\$ 1,231,152	7,715	\$ 221,177	1
2	27	Marketing	Hours Paid	23,634	5	682,736	682,736	3,151	91,029	2
3	21	Information Systems	Hours Paid	176,212	4	6,669,655	6,669,655	2,757	104,350	3
4	21	Finance	Hours Paid	38,786	6	1,265,257	1,265,257	3,054	99,624	4
5	27	Human Resources	Hours Paid	37,616	4	1,140,696	1,140,696	2,499	75,781	5
6	21	Business Office	Hours Paid	192,698	2	3,560,907	3,560,907	7,443	137,548	6
7	17	Executive Salaries	Hours Paid	44,419	4	9,022,263	9,022,263	480	97,500	7
8	22	Pension Expense	Actual FTE	1	1	323,279	0	1	323,279	8
9	22	Workers Comp	FTEs	5,789	5	1,526,643	63,657	241	63,657	9
10	26	Gen/Prof Liability Exp	Actual Expense	1	1	109,355	0	1	109,355	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					\$ 25,531,943	\$ 23,636,323		\$ 1,323,300	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	Mercy Alliance Loan	x		Hospital Renovations	varies	2003	\$ 5,570,000	\$			\$	1
2	Interentity Bond Payable 2012	x		Interco LT Payable	varies	2012	6,650,805	6,154,435			284,199	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 12,220,805	\$ 6,154,435			\$ 284,199	9
	B. Non-Facility Related*											
10	Roche Diagnostics			capital lease	\$168.00	2010	5,893		2016	0.6480		10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				\$168.00		\$ 5,893	\$			\$	14
15	TOTALS (line 9+line14)						\$ 12,226,698	\$ 6,154,435			\$ 284,199	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.)

FACILITY NAME Mercy Harvard Hospital Care COUNTY McHenry
FACILITY IDPH LICENSE NUMBER 8049116
CONTACT PERSON REGARDING THIS REPORT N/A - Property tax exempt
TELEPHONE () FAX #: ()

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.

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: 81,155 B. General Construction Type: Exterior Brick Frame Block Number of Stories 2

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).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Hospital/SNF	85,800	1954	\$ 3,452	1
2					2
3	TOTALS	85,800		\$ 3,452	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					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Metal Lockers			1977	771		20			771	9
10	Door Alarm System			1990	1,055		10			1,055	10
11	Wiring for CC Phones			1990	418		10			418	11
12	Activities Office			1997	19,981		15			19,981	12
13	A/C Compressor			1996	1,922		30			1,922	13
14	Cabinets			1996	11,214		20			11,214	14
15	Wanderguard Unit			2000	2,652		10			2,652	15
16	Construct Firewall			2004	3,761		15			3,761	16
17	Skilled Care Nurse Station			2004	9,522		15			9,522	17
18	Top Upper Cabinet			2005	1,979		10			1,979	18
19	Care Center Wiring			2005	305		7			305	19
20	Patient Rooms			2007	20,000		10			20,000	20
21	Water Heater			2007	8,621		10			8,621	21
22	Care Center Circ Line Plumbing			2008	4,676		10			4,676	22
23	PT Wall Demo			2009	3,250	217	15	217		2,492	23
24	electrical Upgrade			2009	1,384	92	15	92		1,061	24
25	Network Drops			2009	555		5			555	25
26	LTC Driveway			2011	6,677		8			6,677	26
27	LTC Driveway			2011	9,660	644	15	644		6,118	27
28	LTC Roof			2011	17,724	1,772	10	1,772		16,837	28
29	Auto Entrance Doors			2011	4,493	449	10	449		4,269	29
30	HCC Dining Room Remodel			2014	95,000	6,333	15	6,333		41,167	30
31	Security Doors			2015	16,702	1,670	10	1,670		9,186	31
32	Manor Security System			2015	20,063	2,006	10	2,006		11,034	32
33	Security Doors			2015	2,411	241	10	241		1,326	33
34	Replace Windows in Care Center			2016	9,795	980	10	980		4,408	34
35	Replace Broken Windows in Care Center			2016	3,399	340	10	340		1,530	35
36	Auto Doors at Care Center			2017	9,699	978	10	978		3,423	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Nurse Call System	2016	\$ 79	\$ 8	10	\$ 8	\$	\$ 28	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 287,767	\$ 15,731		\$ 15,731	\$	\$ 196,986	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	\$540,445	\$25,273	\$25,273	\$		\$180,023	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	238,334					238,334	73
74								74
75	TOTALS	\$778,778	\$25,273	\$25,273	\$		\$418,357	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$1,069,998	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$41,004	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$41,004	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)	\$615,344	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	Land	\$222,604	\$	\$	86
87	Land Improvements	760,244	28,254	600,519	87
88	Building	21,870,763	793,296	16,401,370	88
89	Equipment	17,286,689	704,295	14,037,286	89
90					90
91	TOTALS	\$40,140,300	\$1,525,845	\$31,039,174	91

G. Construction-in-Progress

	Description	Cost	
92	MHH Pharmacy	\$1,506	92
93			93
94			94
95		\$1,506	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: All rental equipment is short term rental
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: \$ 1,037 Description: Therapy Equip \$475.56, Copier \$111.77, Airgas \$449.18
(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.

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	\$

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.

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	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): n/a - all paid as staff wages									13
14	TOTAL			\$		\$	\$		\$	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	\$ 5,111,861	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,491,134		3
4	Supply Inventory (priced at)	972,172		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,346		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>other accounts receivable</u>	183,571		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 11,769,084	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,074,913		13
14	Buildings, at Historical Cost	22,066,464		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	17,827,134		16
17	Accumulated Depreciation (book methods)	(31,654,517)		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):	1,506		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,315,499	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 21,084,583	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 284,979	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,035,223		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,272		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,845		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other accrued liabilities</u>	2,887,951		36
37	<u>Third party payables</u>	1,027,319		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,267,589	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,201,372		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Unamortized bond fees</u>	(46,937)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,154,435	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,422,024	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 9,662,559	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 21,084,583	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,857,723	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,857,723	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,804,837	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)	\$ 5,804,837	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)	\$ 9,662,559	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mercy Harvard Hospital Care

8049116

Report Period Beginning: 7/1/2019

Ending:

6/30/2020

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	\$ 74,775,845	1
2	Discounts and Allowances for all Levels	(47,308,775)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 27,467,070	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	3,123,338	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	91,075	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	1,986	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,216,398	23
	D. Non-Operating Revenue		
24	Contributions	8,000	24
25	Interest and Other Investment Income***	2,967	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,967	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 30,694,435	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	5,808,591	31
32	Health Care	15,562,743	32
33	General Administration	1,667,216	33
	B. Capital Expense		
34	Ownership	1,851,048	34
	C. Ancillary Expense		
35	Special Cost Centers		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)*	\$ 24,889,598	40
41	Income before Income Taxes (line 30 minus line 40)**	5,804,837	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 5,804,837	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	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	1,752	1,960	\$ 170,321	\$ 86.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	95,577	107,898	4,989,224	46.24	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	28,648	31,604	598,020	18.92	5
6	CNA Trainees					6
7	Licensed Therapist	9,113	10,749	459,247	42.72	7
8	Rehab/Therapy Aides	1,039	1,100	24,960	22.69	8
9	Activity Director	1,816	2,027	41,989	20.71	9
10	Activity Assistants	1,015	1,019	15,445	15.16	10
11	Social Service Workers	1,831	2,091	66,247	31.68	11
12	Dietician	2,131	2,393	77,989	32.59	12
13	Food Service Supervisor	2,505	2,740	64,073	23.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,124	21,929	286,551	13.07	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	13,113	13,964	213,183	15.27	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	5,344	6,089	143,817	23.62	22
23	Office Manager					23
24	Clerical	12,880	14,460	281,753	19.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	209	209	40,188	192.29	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,346	4,898	143,794	29.36	31
32	Other Health Care(specify)	47,085	53,787	2,127,919	39.56	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	248,528	278,917	\$ 9,744,720 *	\$ 34.94	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,375	\$ 171,765	10-3	50
51	Licensed Practical Nurses	574	29,236	10-3	51
52	Certified Nurse Assistants/Aides	1,617	82,279	10-3	52
53	TOTAL (lines 50 - 52)	5,566	\$ 283,280		53

XX. GENERAL INFORMATION:

- | | |
|--|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>No</u>
If YES, give association name and amount. _____</p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>7</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>not available</u> Line _____</p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? YES <u>x</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>x</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>57,187</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation. _____</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>None</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>91,075</u></p> <p>(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> 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? <u>N/A</u>
 d. Have vehicle usage logs been maintained? <u>N/A</u>
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u>
 g. Does the facility transport residents to and from day training? <u>No</u>
 Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____ </p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u>
Firm Name: <u>WIPFLI</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees.</p> |
|--|---|