

STATE OF ILLINOIS

Page 2

Facility Name & ID NumberMercy Circle# 0051201Report Period Beginning: 07/01/2024Ending: 06/30/2025

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

1234

	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	23	Skilled (SNF)	23	8,395	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	23	TOTALS	23	8,395	7

B. Census-For the entire report period.

123456789

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
8	SNF	1,449	365			456	4,008	1,804	8,082	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,449	365			456	4,008	1,804	8,082	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

96.27%

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?YESNOX

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?YESNOX

I. On what date did you start providing long term care at this location?Date started05/01/2014

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

K. Was the facility certified for Medicare during the reporting year?YESXNONOXIf YES, enter certified beds. number of certified beds23

Medicare IntermediaryNational Government Services

IV. ACCOUNTING BASIS

ACCRUALXMODIFIEDCASH* CASH*

Is your fiscal year identical to your tax year?YESXNONOX

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
1	A. General Services	633,141	32,646	315,146	980,933		980,933	(715,487)	265,446		1
2	Dietary		367,286		367,286		367,286	(267,400)	99,886		2
3	Food Purchase	202,099	28,919	111	231,129		231,129	(170,397)	60,732		3
4	Housekeeping			93,863	93,863		93,863	(62,193)	31,670		4
5	Laundry			301,283	301,283		301,283	(240,673)	60,610		5
6	Heat and Other Utilities	284,413	32,114	448,374	764,901		764,901	(611,872)	153,029		6
7	Maintenance										7
8	Other (specify):*										7
8	TOTAL General Services	1,119,653	460,965	1,158,777	2,739,395		2,739,395	(2,068,022)	671,373		8
9	B. Health Care and Programs										
9	Medical Director			28,440	28,440		28,440		28,440		9
10	Nursing and Medical Records	2,335,295	74,051	7,496	2,416,842	(1,256)	2,415,586	(880,263)	1,535,323		10
10a	Therapy										10a
11	Activities	152,959	7,015	19,147	179,121	(280)	178,841	(172,084)	6,757		11
12	Social Services	191,955		7,267	199,222	22,013	221,235	(33,789)	187,446		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,680,209	81,066	62,350	2,823,625	20,477	2,844,102	(1,086,136)	1,757,966		16
17	C. General Administration										
17	Administrative	359,636			359,636		359,636	(215,855)	143,781		17
18	Directors Fees										18
19	Professional Services			647,451	647,451	241,417	888,868	(522,781)	366,087		19
20	Dues, Fees, Subscriptions & Promotions			645,365	645,365	(298,467)	346,898	(246,122)	100,776		20
21	Clerical & General Office Expenses	228,309	(43,382)	87,956	272,883	(13,129)	259,754	(153,962)	105,792		21
22	Employee Benefits & Payroll Taxes			1,412,496	1,412,496	4,714	1,417,210	(741,850)	675,360		22
23	Inservic Training & Education										23
24	Travel and Seminar			6,693	6,693		6,693	(3,936)	2,757		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			105,437	105,437		105,437	(62,012)	43,425		26
27	Other (specify):* Bad Debt/Contrib.			153,589	153,589		153,589	(153,589)			27
28	TOTAL General Administration	587,945	(43,382)	3,058,987	3,603,550	(65,465)	3,538,085	(2,100,107)	1,437,978		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,387,807	498,649	4,280,114	9,166,570	(44,988)	9,121,582	(5,254,265)	3,867,317		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			1,016,067	1,016,067		1,016,067	(827,930)	188,137		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			943,246	943,246		943,246	(786,676)	156,570		32
33	Real Estate Taxes			63,392	63,392		63,392	(52,161)	11,231		33
34	Rent-Facility & Grounds			120,000	120,000		120,000	(120,000)			34
35	Rent-Equipment & Vehicles			34,223	34,223	(680)	33,543	(27,898)	5,645		35
36	Other (specify):*										36
37	TOTAL Ownership			2,176,928	2,176,928	(680)	2,176,248	(1,814,665)	361,583		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			793,725	793,725	(4,906)	788,819	(934)	787,885		39
40	Barber and Beauty Shops			23,242	23,242		23,242		23,242		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					50,574	50,574		50,574		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			816,967	816,967	45,668	862,635	(934)	861,701		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,387,807	498,649	7,274,009	12,160,465		12,160,465	(7,069,864)	5,090,601		45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,430)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(4,098)	6		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(554)	20		18
19	Entertainment				19
20	Contributions	(120,000)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,589)	27		24
25	Fund Raising, Advertising and Promotional	(92,943)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (262,614)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (262,614)		37

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

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

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

Mercy Circle

	ID#	0051201
Report Period Beginning:		07/01/2024
Ending:		06/30/2025

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Political Action Committee Payments	\$ (720)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Miscellaneous Revenue	(491)	10	3
4	Miscellaneous Revenue	(960)	11	4
5	Miscellaneous Revenue	(4,682)	12	5
6	Miscellaneous Revenue	(2,467)	2	6
7	Miscellaneous Revenue	(2,888)	21	7
8	Miscellaneous Revenue	(12,934)	32	8
9	Miscellaneous Revenue	(7,564)	33	9
10	Miscellaneous Revenue	(934)	39	10
11	Miscellaneous Revenue	(116)	6	11
12	Patient Transportation	(727)	10	12
13	Prior Year Expense	(375)	20	13
14	Non Resident Newsletters	(2,712)	20	14
15	Bank Fees	(4,008)	20	15
16	Foundation Expense	(900)	20	16
17	Major Gifts Officer Wages	(10,532)	17	17
18	Major Gifts Officer Payroll Taxes	(810)	22	18
19	Direct - Nursing Wages AL/IL/Memory Care	(875,278)	10	19
20	Direct - Activitiy Director - AL/IL/Memory Care	(53,262)	11	20
21	Direct - Payroll Taxes - AL/IL/Memory Care	(64,108)	22	21
22	Direct - Payroll Taxes - Activity Director - AL/IL/Memor	(4,096)	22	22
23	Direct - Nursing Other Benefits AL/IL/Memory Care	(241,974)	22	23
24	Direct - AL Socisal Service Other Benefits	(13,942)	22	24
25	Direct - Conuslting Fees - AL/IL/Memory Care	(3,767)	10	25
26	Remove Dietary Expense allocated to AL/IL	(704,057)	1	26
27	Remove Housekeeping Expense allocated to AL/IL	(170,397)	3	27
28	Remove Laundry Expense allocated to AL/IL	(62,193)	4	28
29	Remove Utilities allocated to AL/IL	(240,673)	5	29
30	Remove Maintenance Expense allocated to AL/IL	(607,658)	6	30
31	Remove Activity Expense allocated to AL/IL	-117862	11	31
32	Remove Social Service Expense allocated to AL	-29107	12	32
33	Remove Admin Expense allocated to AL/IL	-205323	17	33
34	Remove Professional Services allocated to AL/IL	-522781	19	34
35	Remove Miscellaneous Expense allocated to AL	-143910	20	35
36	Remove Gen Office Expenses allocated to AL/IL	-151074	21	36
37	Remove Travel/Seminar Expense allocated to A	-3936	24	37
38	Remove Insurance Expsnse allocated to AL/IL	-62012	26	38
39	Remove Depreciation Expense allocated to AL/I	-827930	30	39
40	Remove Interest Expense allocated to AL/IL	-773742	32	40
41	Remove Rental Expense allocated to AL/IL	-27898	35	41
42	Remove Benefits allocated to AL/IL	-416920	22	42
43	Remove Food allocated to AL/IL	-264933	2	43
44	Remove Real Estate Taxes allocated to AL/IL	-44597	33	44
45				45
46				46
47				47
48				48
49	Total	(6,687,250)		49

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%					
West Midwest Community, Inc.						

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	32	Interest Expense	393,074	Sisters of Mercy of the Americas West Midwest Comm, Inc.	100.00%	393,074		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			\$ 513,074			\$ 393,074	\$ * (120,000)	14

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

VII. RELATED PARTIES (continued)

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		
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$0	\$ *	39

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

VII. RELATED PARTIES

A. (Continued)

Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	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.

VIII. ALLOCATION OF INDIRECT COSTS

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

YES☐NO☐

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

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 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	Sisters of Mercy of the Americas	X		Refinance 1st Nat'l/WMW	\$85,000.00	6/1/2022	\$ 34,015,053	\$ 32,620,413		0.0120	\$ 393,074	1								
2				FIDES loans - constrution of								2								
3				facility and working capital								3								
4												4								
5												5								
	Working Capital																			
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$85,000.00		\$ 34,015,053	\$ 32,620,413			\$ 393,074	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 34,015,053	\$ 32,620,413			\$ 393,074	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.)

B. Real Estate Taxes

NOTES:

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mercy Circle COUNTY Cook
FACILITY IDPH LICENSE NUMBER 0051201
CONTACT PERSON REGARDING THIS REPORT Pamela Latovick
TELEPHONE (734) 343-6628 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(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>SNF with MC, AL & IL</u>	\$ <u>61,448.60</u>	\$ <u>11,231.00</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>61,448.60</u>	\$ <u>11,231.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 BrickFrame

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 ground (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. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

H. Are you presently operating under a sale and leaseback arrangement?

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized?

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

	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	\$	1,906,818	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Aluminum Logo Sign			2015	631	5	10	5		631	9
10	Parking Lot Paving			2024	3,942	263	15	263		307	10
11	Bldg upgrades			2025	49,672	552	15	552		552	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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	SNF Security System - Upgrade - Skilled NF only	2017	\$ 5,274	\$ 527	10	\$ 527		\$ 4,659	37
38	First Security Syatem - in Skilled NF only	2018	1,920		5			1,920	38
39	HVAC Unit - applicable to Skilled NF only	2018	4,015	402	10	402		2,911	39
40	Linear Electric - applicable to Skilled NF only	2018	2,350		5			2,350	40
41	Complete Electric - applicable to Skilled NF only	2018	2,650		5			2,650	41
42	Dining Equipment - applicable to Skilled NF and AL	2019	6,918	692	10	692		4,209	42
43	Security Cameras - front of building, all areas.	2019	666	67	10	67		405	43
44	Camera in Kitchen - applicable to whole facility	2020	964	96	10	96		562	44
45	Security Nurse Guard/Roam Alert applicable to Skilled NF/AL	2020	1,545	154	10	154		901	45
46	Phone System - applicable to Skilled NF only	2021	12,621	1,262	10	1,262		5,364	46
47	Hot Water Tanks - applicable to Skilled NF and AL	2022	20,041	2,004	10	2,004		6,513	47
48	Steam Table - applicable to Skilled NF/AL	2023	5,603	560	10	560		1,634	48
49	Oven - applicable to Skilled NF/AL	2023	6,137	614	10	614		1,790	49
50	System Network (wifi upgrade) - applicable to Skilled NF/AL	2024	3,269	327	10	327		409	50
51	Phone System - applicable to Skilled NF/AL	2025	604	76	10	76		76	51
52	Refrigerator (Evaporator Coil) - Skilled NF/AL	2025	3,261	489	5	489		489	52
53	Heat Exchanger - Skilled NF/AL	2025	1,391	81	10	81		81	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)		\$ 6,671,136	\$ 171,613		\$ 171,613	\$	\$ 1,945,231	70

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

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	\$ 373,752	\$ 1,497	\$ 1,497	\$		\$ 366,909	71
72	Current Year Purchases	9,873	868	868			868	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 383,625	\$ 2,365	\$ 2,365	\$		\$ 367,777	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	Prior Year - Full Depreciated	Multiple	2007-2013	\$ 107,864	\$	\$	\$	4	\$ 107,865	76
77	Van - Resident Transportation	Chrysler Voyager Van	2022	56,635	14,159	14,159		4	37,756	77
78										78
79										79
80	TOTALS			\$ 164,499	\$ 14,159	\$ 14,159	\$		\$ 145,621	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)	\$ 7,219,260	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 188,137	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 188,137	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)	\$ 2,458,629	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	\$ 9,423,159	86
87	Aluminum Logo Sign, 2015	3,119	26	3,119	87
88	Building Improvements, 2024 & 2025	264,955	4,026	4,243	88
89	Equipment, Prior Years	762,500	14,126	693,152	89
90	Equipment, Current Year	30,998	2,053	2,053	90
91	TOTALS	\$ 33,369,537	\$ 827,930	\$ 10,125,726	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? ☐ YES ☐ NO
- If NO, see instructions.

		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: \$ 34,223 Description: Office Equipment, Postage Meter and Printer
- (Attach a schedule detailing the breakdown of movable equipment)

	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. /2026 | \$ |
| 13. /2027 | \$ |
| 14. /2028 | \$ |

* 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

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	Service	Schedule V Line & Column Reference	2		3	4		5	6	7	8			
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
					Units	Cost								
1	Licensed Occupational Therapist	39-3	hrs	\$			\$	299,403	\$			\$	299,403	1
2	Licensed Speech and Language Development Therapist	39-3	hrs					54,941					54,941	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	39-3	hrs					286,618					286,618	4
5	Physician Care	39-3	visits					22,443					22,443	5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39-3	# of prescripts					113,982					113,982	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Other (specify): <u>Medl Supl/Oxygen</u>	39-3							303				303	12
13	Other (specify): <u>Lab/Xray</u>	39-3						10,195					10,195	13
14	TOTAL			\$			\$	787,582	\$	303		\$	787,885	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,686,720	\$	1
2	Cash-Patient Deposits	21,602		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (25,092))	564,467		3
4	Supply Inventory (priced at)	38,833		4
5	Short-Term Investments	199,233		5
6	Prepaid Insurance	13,376		6
7	Other Prepaid Expenses	118,284		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Shared Service Wages	13,316		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,655,831	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	39,167,947		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,420,852		16
17	Accumulated Depreciation (book methods)	(12,584,352)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Land Lease	1,537,062		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 29,541,509	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 32,197,340	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,917,667	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	260,415		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	303,820		30
	Accrued Taxes Payable (excluding real estate taxes)	291		31
32	Accrued Real Estate Taxes(Sch.IX-B)	117,411		32
33	Accrued Interest Payable	327,676		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,927,280	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	17,562,339		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Restricted Assets/Donations	10,138,662		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 27,701,001	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 32,628,281	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (430,941)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 32,197,340	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,060,420)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,060,420)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(430,943)	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	1,060,422	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 629,479	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)	\$ (430,941)	24

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,088,640	1
2	Discounts and Allowances for all Levels	(664,970)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,423,670	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,033,507	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,033,507	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	26,647	13
14	Non-Patient Meals	11,421	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	17,606	16
17	Sale of Drugs	223,767	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54,674	19
20	Radiology and X-Ray	9,440	20
21	Other Medical Services	103,927	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 447,482	23
D. Non-Operating Revenue			
24	Contributions	824,863	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 824,863	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)	\$ 11,729,522	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,739,395	31
32	Health Care	2,823,625	32
33	General Administration	3,603,550	33
B. Capital Expense			
34	Ownership	2,176,928	34
C. Ancillary Expense			
35	Special Cost Centers	816,967	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)*	\$ 12,160,465	40
41	Income before Income Taxes (line 30 minus line 40)**	(430,943)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (430,943)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 717,457.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	79,186.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	214,525.00	48
49	Medicare Part A	1,834,408.00	49
50	Other-(specify) Hospice/Insurance	234,412.00	50
51	Other-(specify) Assisted Living/Independent Living	6,343,682.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,423,670	56

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2 ^a	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,208	1,856	\$ 135,011	\$ 72.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,321	12,714	651,464	51.24	3
4	Licensed Practical Nurses	7,246	6,404	268,370	41.91	4
5	CNAs & Orderlies	50,470	44,047	1,280,450	29.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,089	1,875	53,494	28.53	9
10	Activity Assistants	4,811	4,232	99,465	23.50	10
11	Social Service Workers	6,792	6,314	213,680	33.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	6,278	6,940	146,977	21.18	14
15	Cook Helpers/Assistants	26,558	24,629	486,163	19.74	15
16	Dishwashers					16
17	Maintenance Workers	10,065	9,294	284,413	30.60	17
18	Housekeepers	10,400	9,142	202,100	22.11	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	7,976	6,900	359,637	52.12	22
23	Office Manager	2,080	1,808	57,241	31.66	23
24	Clerical	7,159	6,566	149,342	22.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,453	142,721	\$ 4,387,807 *	\$ 30.74	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	3-9	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	15	1,535	3-11	44
45	Social Service Consultant	4	280	3-12	45
46	Other(specify) Security	4,056	118,489	3-6	46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,651	\$ 148,744		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

Facility Name & ID Number

Mercy Circle

STATE OF ILLINOIS

#0051201

Report Period Beginning:07/01/2024

Ending:06/30/2025

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XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union'

(2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below

Use the drop down list to identify the association.

Association Name

Amount

LEADING AGE

10,780

10,780

Total

(3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS

OR political action organizations

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1

LEADING AGE

720

720

Total

(4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE

(2 and 3 combined)

LEADING AGE

11,500

11,500

Total

(5)

Indicate the total amount of both disposable and non-disposable incontinent expens

and the location of this expense on Sch. V.

\$11,912

Line3-10

(6)

Have all costs reported on this form been determined using accounting procedures

consistent with prior reports?

Yes

If NO, attach a complete explanation.

(7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department

during this cost report period.

\$50,574

This amount is to be recorded on line 42 of Schedule V.

(8)

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.

(9)

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

(10)

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.

(11)

Indicate the cost of employee meals that has been reclassified to employee benefits

on Schedule V.

\$

Has any meal income been offset against

related costs?

Yes

Indicate the amount.

\$11,430

(12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

Yes

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for

residents?

No

If YES, please indicate the amount of income earned from such a

program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

0

d. Have vehicle usage logs been maintained?

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.

\$

(13)

Has an audit been performed by an independent certified public accounting firm

Firm Name:

No

(14)

Have all costs which do not relate to the provision of long term care been adjusted out

out of Schedule V?

Yes

(15)

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:

2.00 Grand Total

**Mercy Circle
Additional Support - Reclass Support
FYE 6-30-2025**

	Wage Reclasses	Nursing Supplies	Professional Services	Dues	Equipment Lease	Consulting Fees	Purchased Services	Travel Reclass	Total Reclass
1	Dietary								-
2	Food Purchase								-
3	Housekeeping								-
4	Laundry								-
5	Heat and Other Utilities								-
6	Maintenance								-
7	Other (specify):*								-
9	Medical Director								-
10	Nursing and Medical Records		(1,256)						(1,256)
10a	Therapy								-
11	Activities					(280)			(280)
12	Social Services	21,726		7		280			22,013
13	CNA Training								-
14	Program Transportation								-
15	Other (specify):*								-
17	Administrative	-							-
18	Directors Fees								-
19	Professional Services		(103)	241,519					241,417
20	Dues, Fees, Subscriptions & Promotions		103	(299,909)		1,340			(298,466)
21	Clerical & General Office Expenses	(21,726)	108		680				(13,129)
22	Employee Benefits & Payroll Taxes					4,714			4,714
23	Inservice Training & Education								-
24	Travel and Seminar								-
25	Other Admin. Staff Transportation								-
26	Insurance-Prop Liah.Malpractice								-
27	Other (specify):*								-
30	Depreciation								-
31	Amortization of Pre-Op. & Org.								-
32	Interest								-
33	Real Estate Taxes								-
34	Rent-Facility & Grounds								-
35	Rent-Equipment & Vehicles				(680)				(680)
36	Other (specify):*								-
38	Medically Necessary Transportation								-
39	Ancillary Service Centers		1,148			(6,054)			(4,906)
40	Barber and Beauty Shops								-
41	Coffee and Gift Shops								-
42	Provider Participation Fee			50,574					50,574
43	Other (specify):*								-
		-	-	-	-	-		-	0

Mercy Circle
Adjustments to Expense
FYE 6-30-25

<u>Description</u>	<u>Amount</u>	<u>Line #</u>	<u>WP</u>	
Meal Income	(11,430)	1 TB		
Garage/Parking Fees	-	6 TB		
Transportation Revenue	(4,098)	6 TB		
Miscellaneous Revenue	(491)	10 Misc Income	Administrative/LTC only	
	(960)	11 Misc Income		
	(4,682)	12 Misc Income		
	(2,467)	2 Misc Income		
	(2,888)	21 Misc Income		
	(12,934)	32 Misc Income		
	(7,564)	33 Misc Income		
	(934)	39 Misc Income		
	(116)	6 Misc Income		
Patient Transportation	(727)	10 TB - Offsetting Lesser of Expense/Misc Revenue		
Interest Income	-	32 TB		
Bad Debt Expense	(33,589)	27 TB		
Fundraiser Expense	(2,662)	20 MC Dues & Subscriptions		
Not Current Year Memberships	(375)	20 MC Dues & Subscriptions		
Lobbying Portion of Dues	(720)	20 MC Dues & Subscriptions		
Marketing Expense	(90,281)	20 MC Dues & Subscriptions		
Non-Resident News Letter	(2,712)	20 MC Dues & Subscriptions		
Fines and Penalties	(554)	20 MC Dues & Subscriptions		
Bank Fees	(4,008)	20 MC Dues & Subscriptions		
Foundation Expense	(900)	20 MC Dues & Subscriptions		
Major Gifts Officer	(10,532)	17 Payroll		
Major Gifts Officer FICA	(810)	22 FICA - 7.69% of Major Gifts Wages Removed		
Contributions	(120,000)	27 TB		
Medical Director over Accrual	-	9 Expense Breakdown		
Travel Expense over Accrual	-	24 Expense Breakdown		
Land Lease	(120,000)	34 TB		
Wound Care	-	39 Consulting Fees		
Total	(436,432)			

Mercy Circle
Additional Support - Adjustments to AL/IL Expense
FYE 6-30-25

Direct Expense for AL/IL and MC

Description	Amount	Line #
Consulting Fees	3,767	10
Nursing Wages	875,278	10
Nursing Benefits - FICA	64,408	22
Nursing Benefits - Other	241,974	22
AL Director Wages	53,262	12 (Payroll)
AL Director FICA Calc	4,096	22 Calculated
AL Director Benefits - Othe	13,941	22
Total	1,256,426	

Allocated Expense for AL/IL and MC

Line #	1	2	3	4	5	6	11	12	17	19	20	21	24	26	30	32	33	35	Total
Cost Center	Dietary	Food	Housekpg	Laundry	Utilities	Maintenance	Activities	Soc. Svcs.	Admin	Prof Svcs	Misc.	Gen Office	Trav/Sem	Insurance	Depreciation	Interest	Real Est Taxes	Rent Equip	
Direct Expense	969,503	364,819	231,129	93,863	301,283	760,687	177,881	216,553	349,104	888,868	244,686	256,866	6,693	105,437	1,016,067	930,312	55,828	33,543	7,003,122
Benefits	204,380	-	65,239	-	-	91,809	49,376	50,939	116,092	-	-	66,686	-	-	-	-	-	-	644,521
Total Expense to Allocate	1,173,883	364,819	296,368	93,863	301,283	852,496	227,257	267,492	465,196	888,868	244,686	323,552	6,693	105,437	1,016,067	930,312	55,828	33,543	7,647,643
Direct Expense																			
AL	521,269	196,151	75,576	62,193	75,425	190,434	117,862	20,957	147,777	376,260	103,576	108,732	2,833	44,632	-	-	13,976	-	2,057,651
IL	182,788	68,782	94,821	-	165,249	417,224	-	8,150	57,546	146,521	40,334	42,342	1,103	17,380	827,930	773,742	30,621	27,898	2,902,431
SNF	265,446	99,886	60,732	31,670	60,610	153,029	60,019	187,446	143,781	366,087	100,776	105,792	2,757	43,425	188,137	156,570	11,231	5,645	2,043,040
Total	969,503	364,819	231,129	93,863	301,283	760,687	177,881	216,553	349,104	888,868	244,686	256,866	6,693	105,437	1,016,067	930,312	55,828	33,543	7,003,122
Benefits																			
AL	109,888		21,332			22,984	32,716	4,930	49,142					28,228					269,220
IL	38,533		26,764			50,356	-	1,917	19,137					10,992					147,700
SNF	55,958		17,142			18,469	16,660	44,093	47,813					27,465					227,601
Total	204,380		65,239			91,809	49,376	50,939	116,092					66,686					644,521
Statistic	Meals		Adj Sq Ftg	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	47,613	47,613	30,160	15,871	30,160	30,160	15,871	18	2,708,141	2,708,141	2,708,141	2,708,141	2,708,141	2,708,141			30,160		
IL	16,696	16,696	37,840	-	66,078	66,078	-	7	1,054,586	1,054,586	1,054,586	1,054,586	1,054,586	1,054,586	827,930	32,311,084	66,078	32,311,084	
SNF	24,246	24,246	24,236	8,082	24,236	24,236	8,082	161	2,634,923	2,634,923	2,634,923	2,634,923	2,634,923	2,634,923	188,137	6,538,294	24,236	6,538,294	
Total	88,555	88,555	92,236	23,953	120,474	120,474	23,953	186	6,397,650	6,397,650	6,397,650	6,397,650	6,397,650	6,397,650	1,016,067	38,849,377	120,474	38,849,377	
	27%	27%	26%	34%	20%	20%	34%	87%	41%	41%	41%	41%	41%	41%	19%	17%	20%	17%	

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

Mercy Circle
Additional Support - Professional Services
FYE 6-30-25

Professional Services - Line 19

Vendor Name	Service Provided	TB Amount	Reclasses	Total
CERTISURV LLC	Informal Dispute Relations (IDR)	400.00		400.00
FLAMM AND TEIBLOOM LLC	General Counsel - Tax Exempt Status & Overpayments	3,931.25		3,931.25
GOLAN CHRISTIE TAGLIA LLP	Assesor's Fee - 40% of 100K saved	41,541.46		41,541.46
JACKSON LEWIS PC	Employee/HR Related Counsel	1,540.35		1,540.35
KOLEY JESSEN PC LLO	Forbearance Agreement	6,633.00		6,633.00
ONE SOURCE INC	Background Checks	102.75	(102.75)	-
PLANTE & MORAN PLLC	Accounting Services	45,000.00		45,000.00
POLSINELLI PC	IDR Policies including F607 and F880.	8,973.00		8,973.00
Trinity Health	Management Services	539,329.62	217,947.70	757,277.32
SHEILA KING	General Client Services & Community Outreach		23,571.75	23,571.75
Total Professional Services (Line 19 - Column 3)		647,451.43	241,416.70	888,868.13
Removed as AL/IL Allocations				(522,781.00)
Total Professional Services (Line 19 - Column 8)				366,087.13

Mercy Circle
Additional Support - Legal Invoices
FYE 6-30-25

Vendor Name	Voucher Nbr	Invoice	Invoice Date	Description	Amount	Hours
CERTISURV LLC	00011648	947	2025-03-11	Hourly IDR Fee	400.00	4.00
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	Call from Frances Lachowicz re claim for refund of overpaid taxes	106.25	0.25
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	investigate status of taxes paid and due; correspondence with Frances Lachowicz re same	425.00	1.00
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	correspondence with AB, Frances Lachowicz re missing CoFE payment	106.25	0.25
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	review status of refunds; correspondence with Frances Lachowicz	531.25	1.25
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	review agreement re collecting tax refunds from County, call Frances Lachowicz re same, also re		
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	board member who thinks property should be totally exempt	212.50	0.50
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	investigate taxes and exemption; correspondence with client and atty. Rubin re same	212.50	0.50
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	review past files re assessed value; conference and correspondence with Frances Lachowicz and atty.		
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	Donald Rubin	531.25	1.25
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	review law and facts; correspondence with Frances Lachowicz and atty. Rubin re application of		
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	exemption to land and building, also re no requirement to file annual affidavit	743.75	1.75
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	review documents; correspondence with client re tax exemption, valuation increase	425.00	1.00
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	call atty. Rubin re reason for large increase in land valuation	106.25	0.25
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	correspondence with atty Don Rubin re assessment appeal	106.25	0.25
FLAMM AND TEIBLOOM LLC	00010872	2149	2024-12-03	review noticed of tax reduction, history of assessed valuation; correspondence with Frances	425.00	1.00
GOLAN CHRISTIE TAGLIA LLP	00011380	208277	2024-11-20	2024 Assessor's Office - 40% fee for savings of 103,853.66	41,541.46	-
JACKSON LEWIS PC	00009868	8557238	2024-07-17	Consider issues raised by Susan Tirpak about floating holidays, email with Tirpak about same.	157.95	0.30
JACKSON LEWIS PC	00009868	8557238	2024-07-17	Email with Susan Tirpak about floating holidays	157.95	0.30
JACKSON LEWIS PC	00010589	8628504	2024-10-22	Confer with Susan Tirpak by phone and email regarding defamatory google review	106.72	0.20
JACKSON LEWIS PC	00010589	8628504	2024-10-22	Email with Susan Tirpak about audit request.	53.36	0.10
JACKSON LEWIS PC	00010589	8628504	2024-10-22	Exchange emails with auditors from Plant Moran, draft audit letter response	213.44	0.40
JACKSON LEWIS PC	00010589	8628504	2024-10-22	Attend to inquiry regarding employee taking of employee information, related risks, issues, analysis.	160.08	0.30
JACKSON LEWIS PC	00010589	8628504	2024-10-22	Finalize audit letter response, email with Austin Chambe (Plant Morane) about same.	106.72	0.20
JACKSON LEWIS PC	00010589	8628504	2024-10-22	Investiage issues regarding confidentiality and privacy of employee list, exchange emails with Susan		
JACKSON LEWIS PC	00010589	8628504	2024-10-22	Tirpak about same.	266.80	0.50
JACKSON LEWIS PC	00010589	8628504	2024-10-22	Consider issues related to HR employee's decision to emailing herself a list of employees, then		
JACKSON LEWIS PC	00010589	8628504	2024-10-22	provide advice on next steps.	106.72	0.20
JACKSON LEWIS PC	00010774	8648195	2024-11-18	Consider issues regarding Victor Martinez leave accommodations, and advise Susan Tirpak about		
JACKSON LEWIS PC	00010774	8648195	2024-11-18	same by email.	210.60	0.40
KOLEY JESSEN PC LLO	00010359	503649	2024-09-12	Telephone conference with Frances Lachowica regarding forbearance discussions and agreement		
KOLEY JESSEN PC LLO	00010359	503649	2024-09-12	with Sisters of Mercy.	99.00	0.20
KOLEY JESSEN PC LLO	00010359	503649	2024-09-12	Receipt and review of Forbearance Agreement and related letter from Sisters of Mercy and comments		
KOLEY JESSEN PC LLO	00010359	503649	2024-09-12	to same.	495.00	1.00
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Telephone conference with Frances Lachowicz regarding new Forebearance Agreement; review of		
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Forebearance Agreement and comments to same.	594.00	1.20
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Review of Senior Secured Promissory Note and Forbearance Agreement and preparation of summary		
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	comparison of terms; telephone conference with client to discuss Forebearance Agreement.	990.00	2.00
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Attend Mercy Circle virtual Board meeting to discuss proposed Forbearance Agreement and follow up		
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	with Frances Lachowicz and Mike Davis regarding Forebearance Agreement.	643.50	1.30
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Work on revisions and comments to Forbearance Agreement and finalize same; email		
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	correspondence to Frances Lachowicz and Mike Davis regarding same.	742.50	1.50
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Telephone conference with Mercy Circle representatives regarding Loan Forbearance Agreement;		
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	work on revisions to Forebearance Agreement incorporating changes discussed during call.	990.00	2.00
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Telephone Conference with Frances Lachowicz regarding revised Forbearance Agreement received		
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	from SMA.	247.50	0.50
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Telephone conference with Mike Davis and Frances Lachowicz regarding revised Forbearance		
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Agreement received from SMA; review of revised SMA and work on revisions to same.	346.50	0.70
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Revise and finalize changes to Forbearance Agreement and email correspondence to client regarding		
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	same; telephone conference with Frances Lachowicz to discuss addition changes to Forbearance		
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Agreement and revision of same; email revised Forbearance Agreement to Frances Lachowicz and		
KOLEY JESSEN PC LLO	00010834	509601	2024-11-13	Mike Davis.	346.50	0.70
KOLEY JESSEN PC LLO	00012221	507788	2024-10-15	Receipt and review of email correspondence and appraisal from Frances Lachowicz and respond to		
KOLEY JESSEN PC LLO	00012221	507788	2024-10-15	same; work on revisions to Forbearance Agreement letter and finalize same; email correspondence to		
KOLEY JESSEN PC LLO	00012221	507788	2024-10-15	Frances and Michael regarding same.	742.5	1.50
KOLEY JESSEN PC LLO	00012221	507788	2024-10-15	Telephone conference with Frances Lachowicz regarding 2024 waiver letter and preparation of same;		
KOLEY JESSEN PC LLO	00012221	507788	2024-10-15	email 2024 waiver letter to Frances Lachowicz.	247.5	0.50
KOLEY JESSEN PC LLO	00012222	511660	2024-12-10	Receipt and review of revised Forbearance Agreement and email correspondence to Frances		
POLSINELLI PC	00011894	2624849	2025-04-30	Lachowicz and Michael Davis regarding same.	148.5	0.30
POLSINELLI PC	00011894	2624849	2025-04-30	Review final IDR determination and follow up with Ms. Lachowicz on final determination.	203	0.20
POLSINELLI PC	00011894	2624849	2025-04-30	Review and revise 5 day report and summary; discuss same with Ms. Lachowicz.	1116.5	1.10
POLSINELLI PC	00012029	2609969	2025-03-31	Review of survey and IDPh correspondence; conference call with Ms. Lachowicz regarding training of		
POLSINELLI PC	00012029	2609969	2025-03-31	staff on abuse and policies re abuse and QAPI.	2334.5	2.30
POLSINELLI PC	00012029	2609969	2025-03-31	Researched State Operations Manual regarding QAPI guidance for substandard level of care and		
POLSINELLI PC	00012029	2609969	2025-03-31	summarized guidance on tag.	560	0.80
POLSINELLI PC	00012029	2609969	2025-03-31	Call with Ms. Lachowicz and Ms. Dozark to review survey and information for IDR; review of		
POLSINELLI PC	00012029	2609969	2025-03-31	documentation and policies; draft IDR response.	4263	4.20
POLSINELLI PC	00012029	2609969	2025-03-31	Finalize IDR for F607 and F880; finalize exhibits; file IDR request.	5481	5.40
POLSINELLI PC	00012029	2609969	2025-03-31	Follow up with Certi-surv on IDR meeting and exhibits.	203	0.20
POLSINELLI PC	00012029	2609969	2025-03-31	Follow up on new IDR meeting; follow up on prep meeting.	304.5	0.30

Mercy Circle
Additional Support - Consultants
FYE 6-30-2025

Medical Director

Vendor	Invoice	Invoice Date	Amount	Hours
OSF HEALTHCARE	127126291SEP24	2024-09-30	2,370.00	48.00
OSF HEALTHCARE	128502135DEC24	2024-12-31	2,370.00	48.00
OSF HEALTHCARE	128502135NOV24	2024-11-30	2,370.00	48.00
OSF HEALTHCARE	3120619JAN3125	2025-01-31	2,370.00	48.00
OSF HEALTHCARE	3120619103124	2024-10-31	2,370.00	48.00
OSF HEALTHCARE	3120619FEB25 JRNL	2025-02-28	2,370.00	48.00
OSF HEALTHCARE	310325	2025-03-31	2,370.00	48.00
OSF HEALTHCARE	3120619APR25	2025-04-30	2,370.00	48.00
OSF HEALTHCARE	120930351MAY24	2024-05-01	2,370.00	48.00
OSF HEALTHCARE	119439150APR24	2024-04-01	2,370.00	48.00
OSF HEALTHCARE	31206194	2024-06-01	2,370.00	48.00
OSF HEALTHCARE	123834303	2024-07-31	2,370.00	48.00
OSF HEALTHCARE	125406510AUG24	2024-08-01	2,370.00	48.00
	vendor accruals		(2,370.00)	(48.00)
Total OSF HEALTHCARE - Medical Director			28,440.00	576.00

Activity Consultant

Vendor	Invoice	Invoice Date	Amount	Hours
SOCIALWORK CONSULTATION GROUP	18426	2024-07-31	350.00	5.00
SOCIALWORK CONSULTATION GROUP	19578	2025-01-31	390.50	5.00
SOCIALWORK CONSULTATION GROUP	18906	2024-10-31	332.50	4.75
Total SOCIAL WORK CONSULTATION GROUP - Activities			1,073.00	14.75

Social Services Consultant

Vendor	Invoice	Invoice Date	Amount	Hours
SOCIALWORK CONSULTATION GROUP	18426	2024-07-31	280.00	4.00
Total SOCIAL WORK CONSULTATION GROUP - Social Services			280.00	4.00

Security Consultant

Vendor	Invoice	Invoice Date	Amount	Hours
SECURITY LOGISTICS GROUP INC	3293	2024-08-01	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3281	2024-07-18	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3280	2024-07-04	4,104.00	132.00
SECURITY LOGISTICS GROUP INC	3343	2024-08-15	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3377	2024-08-29	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3402	2024-09-12	4,959.00	168.00
SECURITY LOGISTICS GROUP INC	3426	2024-09-26	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3460	2024-10-10	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3476	2024-10-24	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3533	2024-11-21	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3499	2024-11-07	4,659.75	163.50
SECURITY LOGISTICS GROUP INC	3550	2024-12-05	4,959.00	144.00
SECURITY LOGISTICS GROUP INC	3590	2024-12-19	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3637	2025-01-02	6,498.00	174.00
SECURITY LOGISTICS GROUP INC	3684	2025-01-30	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3667	2025-01-16	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3714	2025-02-13	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3769	2025-03-13	4,745.25	166.50
SECURITY LOGISTICS GROUP INC	3800	2025-03-27	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3745	2025-02-27	4,788.00	168.00
SECURITY LOGISTICS GROUP INC	3816	2025-04-10	4,773.75	167.50
	vendor accruals		16,758.00	588.00
Total SECURITY LOGISITICS GROUP INC - Security			16,758.00	588.00