



Facility Name & ID Number Mercy Harvard Hospital Care

# 8049116 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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>16,425</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>45</u>	TOTALS	<u>45</u>	<u>16,425</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>975</u>	<u>4,264</u>	<u>3,273</u>	<u>8,512</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>975</u>	<u>4,264</u>	<u>3,273</u>	<u>8,512</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.82%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold 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 March 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 3,032

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/2014 Fiscal Year: 6/30/2014

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

Facility Name &amp; ID Number

Mercy Harvard Hospital Care

# 8049116

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

**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
	<b>A. General Services</b>										
1	Dietary	351,136	36,521	135,666	523,323	(2,510)	520,813	(66,503)	454,310		1
2	Food Purchase										2
3	Housekeeping	195,772	19,487	32,855	248,114	(200)	247,914	(208,287)	39,627		3
4	Laundry		699	2,100	2,799		2,799	(1,678)	1,121		4
5	Heat and Other Utilities					305,938	305,938	(257,037)	48,901		5
6	Maintenance		417	875,103	875,520	(308,337)	567,183	(476,525)	90,658		6
7	Other (specify):* <b>SPD &amp; Light Duty</b>	60,749	1,004	4,175	65,928		65,928	(8,418)	57,510		7
8	<b>TOTAL General Services</b>	607,657	58,128	1,049,899	1,715,684	(5,109)	1,710,575	(1,018,448)	692,127		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	5,252,741	1,194,470	2,369,012	8,816,224	(5,793,895)	3,022,329	(138,907)	2,883,422		10
10a	Therapy	522,817	14,034	44,828	581,679	(12,957)	568,722	(72,620)	496,102		10a
11	Activities										11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Rad, Lab, Pharm, PT</b>	1,459,144	199,131	2,467,105	4,125,379	(4,125,379)	0		0		15
16	<b>TOTAL Health Care and Programs</b>	7,234,702	1,407,635	4,880,945	13,523,282	(9,932,231)	3,591,051	(211,527)	3,379,524		16
	<b>C. General Administration</b>										
17	Administrative	54,535	1,805	873,805	930,146	(129,227)	800,919	(763,222)	37,697		17
18	Directors Fees										18
19	Professional Services					12,715	12,715	(6,153)	6,562		19
20	Dues, Fees, Subscriptions & Promotions					76,854	76,854	(37,191)	39,663		20
21	Clerical & General Office Expenses	256,548	4,181	653,482	914,211	(5,397)	908,814	(439,798)	469,016		21
22	Employee Benefits & Payroll Taxes			2,213,749	2,213,749	(318,564)	1,895,185	(1,521,737)	373,448		22
23	Inservice Training & Education										23
24	Travel and Seminar					28,345	28,345	(13,717)	14,628		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			61,284	61,284	191,248	252,532	(220,905)	31,627		26
27	Other (specify):* <b>Marketing, HR</b>	8,371	669	310,415	319,455	(10,317)	309,138	(248,222)	60,916		27
28	<b>TOTAL General Administration</b>	319,455	6,655	4,112,736	4,438,845	(154,343)	4,284,502	(3,250,945)	1,033,557		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	8,161,814	1,472,417	10,043,580	19,677,811	(10,091,683)	9,586,128	(4,480,920)	5,105,208		29

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

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

Facility Name & ID Number Mercy Harvard Hospital Care

#8049116

Report Period Beginning: 07/01/2013 Ending: 06/30/2014

06/30/2014

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			1,841,836	1,841,836		1,841,836	(1,809,607)	32,229			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			571,501	571,501		571,501	(571,501)	(0)			32
33	Real Estate Taxes					54,572	54,572	(54,572)	(0)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					30,402	30,402	(20,151)	10,251			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,413,337	2,413,337	84,974	2,498,311	(2,455,831)	42,480			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					9,954,105	9,954,105	(9,954,105)	0			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					52,603	52,603		52,603			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>					10,006,709	10,006,709	(9,954,105)	52,604			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	8,161,814	1,472,417	12,456,916	22,091,148	(0)	22,091,147	(16,890,856)	5,200,291			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

Facility Name & ID Number Mercy Harvard Hospital Care

# 8049116

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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)				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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	30

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

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

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology	x		see schedule	15	42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule	x		see schedule	10,15,22	45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

## Mercy Harvard Hospital Care

ID#	8049116
Report Period Beginning:	07/01/2013
Ending:	06/30/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Dietary Expense not related to SNF Care	\$ (66,503)	1	1
2	Housekeeping Expenses not related to SNF Care	(208,287)	3	2
3	Laundry Expenses not related to SNF Care	(1,678)	4	3
4	Heat & Other Utilities not related to SNF Care	(257,037)	5	4
5	Maintenance Expenses not related to SNF Care	(476,525)	6	5
6	Central Supply Expense not related to SNF Care	(8,418)	7	6
7	Nursing & Medical Records Exp not related to SNF	(138,907)	10	7
8	Therapy Expenses not related to SNF Care	(72,620)	10a	8
9	Administrative Expenses not related to SNF Care	(387,585)	17	9
10	Professional Services not related to SNF Care	(6,153)	19	10
11	Dues, Fees & Subscriptions not related to SNF	(37,191)	20	11
12	Clerical & General Office Exp not related to SNF	(439,798)	21	12
13	Employee Ben & Payroll Taxes not related to SNF	(1,521,737)	22	13
14	Travel & Seminar Expense not related to SNF	(13,717)	24	14
15	Insurance Expenses not related to SNF Care	(220,905)	26	15
16	Human Res & Marketing Exp not related to SNF	(248,222)	27	16
17	Depreciation Expense not related to SNF Care	(1,809,607)	30	17
18	Interest Expense not related to SNF Care	(571,501)	32	18
19	Real Estate Taxes not related to SNF Care	(54,572)	33	19
20	Rent Expense - Equipment not related to SNF Care	(20,151)	35	20
21	Ancillary Services related to Acute - not SNF Oper	(9,954,105)	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	<b>Total</b>	(16,515,219)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Harvard Hospital Care# 8049116

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

## 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	(66,503)	0	0	0	0	0	0	0	0	0	0	(66,503)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(208,287)	0	0	0	0	0	0	0	0	0	0	(208,287)	3
4	Laundry	(1,678)	0	0	0	0	0	0	0	0	0	0	(1,678)	4
5	Heat and Other Utilities	(257,037)	0	0	0	0	0	0	0	0	0	0	(257,037)	5
6	Maintenance	(476,525)	0	0	0	0	0	0	0	0	0	0	(476,525)	6
7	Other (specify):*	(8,418)	0	0	0	0	0	0	0	0	0	0	(8,418)	7
8	<b>TOTAL General Services</b>	<b>(1,018,448)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,018,448)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(138,907)	0	0	0	0	0	0	0	0	0	0	(138,907)	10
10a	Therapy	(72,620)	0	0	0	0	0	0	0	0	0	0	(72,620)	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	<b>TOTAL Health Care and Programs</b>	<b>(211,527)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(211,527)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(387,585)	0	0	0	0	0	0	0	0	0	0	(387,585)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,153)	0	0	0	0	0	0	0	0	0	0	(6,153)	19
20	Fees, Subscriptions & Promotions	(37,191)	0	0	0	0	0	0	0	0	0	0	(37,191)	20
21	Clerical & General Office Expenses	(439,798)	0	0	0	0	0	0	0	0	0	0	(439,798)	21
22	Employee Benefits & Payroll Taxes	(1,521,737)	0	0	0	0	0	0	0	0	0	0	(1,521,737)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(13,717)	0	0	0	0	0	0	0	0	0	0	(13,717)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(220,905)	0	0	0	0	0	0	0	0	0	0	(220,905)	26
27	Other (specify):*	(248,222)	0	0	0	0	0	0	0	0	0	0	(248,222)	27
28	<b>TOTAL General Administration</b>	<b>(2,875,308)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,875,308)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(4,105,283)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,105,283)</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name & ID Number Mercy Harvard Hospital Care# 8049116

Report Period Beginning:

07/01/2013 Ending:

Summary B

06/30/2014

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	(1,809,607)	0	0	0	0	0	0	0	0	0	0	(1,809,607)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(571,501)	0	0	0	0	0	0	0	0	0	0	(571,501)	32
33	Real Estate Taxes	(54,572)	0	0	0	0	0	0	0	0	0	0	(54,572)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(20,151)	0	0	0	0	0	0	0	0	0	0	(20,151)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,455,831)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,455,831)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(9,954,105)	0	0	0	0	0	0	0	0	0	0	(9,954,105)	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	<b>TOTAL Special Cost Centers</b>	<b>(9,954,105)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,954,105)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(16,515,219)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(16,515,219)</b>	<b>45</b>

**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 System	100			Mercy Hospital	Janesville	Hospital
				Mercy Assisted Care	Janesville	Includes Homecare
				Mercy Alliance	Janesville	Parent Corp
				Mercy Walworth Hosp	Lake Geneva	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		\$			\$	\$	1
2	V							2
3	V			N/A				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	<b>Total</b>		\$			\$	\$ *	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	N/A							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

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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

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

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

Facility Name & ID Number Mercy Harvard Hospital Care

# 8049116 Report Period Beginning: 07/01/2013

Ending: 6/30/2014

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

Name of Related Organization Mercy Health System  
 Street Address 1000 Mineral Point Avenue  
 City / State / Zip Code Janesville, WI 53546  
 Phone Number (608)755-5362 x5012  
 Fax Number (608)741-7368

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	Hours Worked	47,243	3	\$ 1,274,304	\$ 1,274,304	8,163	\$ 220,188	1
2	27	Marketing	Hours Worked	34,961	5	948,458	948,458	3,150	85,469	2
3	21	Information Systems	Hours Worked	174,225	4	5,692,171	5,692,171	2,686	87,750	3
4	21	Finance	Hours Worked	46,892	6	1,500,328	1,500,328	3,736	119,531	4
5	27	Human Resources	Hours Worked	42,606	4	1,287,206	1,287,206	2,480	74,930	5
6	21	Business Office	Hours Worked	219,288	2	3,407,313	3,407,313	13,954	216,819	6
7	17	Executive Salaries	Hours Worked	42,727	4	6,629,214	6,629,214	604	93,750	7
8	22	Pension Expense	Actual Expense	1	1	267,653	0	1	267,653	8
9	22	Worker's Comp	FTE's	2,943	5	1,549,181	70,451	134	70,451	9
10	26	Gen/Prof Liability Exp	Actual Expense	1	1	61,284	0	1	61,284	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					\$ 22,617,112	\$ 20,809,445		\$ 1,297,825	25

Facility Name & ID Number

Mercy Harvard Hospital Care

# 8049116

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Mercy Alliance Loan	x		Hospital Renovations	varies	2003	\$ 5,570,000	\$ 5,816,408			\$ 276,279	1					
2	Interentity Bond Payable 2012	x		Intercompany LT Payable	varies	2012	6,650,805	6,620,693			291,956	2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 12,220,805	\$ 12,437,101			\$ 568,235	9					
<b>B. Non-Facility Related*</b>																	
10	Roche Diagnostics			Capital Lease	\$168.00	2010	5,893	4,209	2016	0.0648	332	10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>				\$168.00		\$ 5,893	\$ 4,209			\$ 332	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 12,226,698	\$ 12,441,310			\$ 568,567	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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.			\$	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2	
3. Under or (over) accrual (line 2 minus line 1).			\$	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009 _____	8	<b>FOR BHF USE ONLY</b>		
	2010 _____	9			
	2011 _____	10			
	2012 _____	11			
	2013 _____	12			
<b>N/A - Hospital Property classified as not for profit - Tax Exempt</b>					
			13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
			14	PLUS APPEAL COST FROM LINE 5 \$	14
			15	LESS REFUND FROM LINE 6 \$	15
			16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

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

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

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 #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2013 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 2013.

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

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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).

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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
	<b>Improvement Type**</b>									
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	30	30		1,922	13
14	Cabinets	1996		11,214	561	20	561		10,144	14
15	Wanderguard	2000		2,652		10			2,652	15
16	Construct Firewall	2004		3,761	251	15	251		2,633	16
17	Skilled Care Nurse Station	2004		9,522	635	15	635		6,665	17
18	Top Upper Cabinet	2005		1,979	198	10	198		1,880	18
19	Care center Wiring	2005		305		7			305	19
20	Paint rooms	2007		20,000	2,000	10	2,000		15,000	20
21	Water Heater	2007		8,621	862	10	862		6,465	21
22	Care Center Circ Line Plumbing	2008		4,676	468	10	468		3,039	22
23	PT Wall Demo	2009		3,250	217	15	217		1,192	23
24	Electrical Upgrade	2009		1,384	92	15	92		507	24
25	Network Drops	2009		555	56	5	56		555	25
26	LTC Driveway	2011		6,677	835	8	835		2,921	26
27	LTC Driveway	2011		9,660	644	15	644		2,254	27
28	LTC Roof	2011		17,723	1,772	10	1,772		6,203	28
29	Auto Entrance Doors	2011		4,493	449	10	449		1,573	29
30	HCC Dining Room Remodel	2014		95,000	3,167	15	3,167		3,167	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

Facility Name & ID Number Mercy Harvard Hospital Care

# 8049116

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

**XI. OWNERSHIP COSTS (continued)**

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 225,620	\$ 12,235		\$ 12,235	\$	\$ 91,303	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	\$ 231,628	\$ 18,431	\$ 18,431	\$		\$ 107,511	71
72	Current Year Purchases	13,695	940	940			940	72
73	Fully Depreciated Assets	164,332	623	623			164,332	73
74								74
75	TOTALS	\$ 409,655	\$ 19,993	\$ 19,993	\$		\$ 272,782	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 638,726	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,229	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,229	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)	\$ 364,085	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	\$ 19,894,683	\$ 902,578	\$ 11,665,059	86
87	Equipment	13,164,115	866,933	9,253,365	87
88	Land Improvements	706,427	20,792	528,776	88
89					89
90					90
91	TOTALS	\$ 33,765,224	\$ 1,790,303	\$ 21,447,199	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Mercy Harvard Hospital Care

# 8049116

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

**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

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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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: \$ 10,251 Description: Therapy Equip - \$6,355.03 Copier \$1,596 Gas Cylinders \$2,299.91  
(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.

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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 prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>N/A - All paid as staff wages</u>									13	
14	<b>TOTAL</b>			\$		\$	\$		\$	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.**

Facility Name & ID Number Mercy Harvard Hospital Care# 8049116Report Period Beginning: 07/01/2013

Ending:

06/30/2014

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 896,201	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>7,420,232</u> )	5,004,493		3
4	Supply Inventory (priced at )	568,271		4
5	Short-Term Investments			5
6	Prepaid Insurance	120,496		6
7	Other Prepaid Expenses	64,227		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 6,653,688	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	929,031		13
14	Buildings, at Historical Cost	20,120,302		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,573,770		16
17	Accumulated Depreciation (book methods)	(21,811,285)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Unamortized Bond Fees</u>	61,825		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 12,873,643	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 19,527,331	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 188,514	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	722,640		30
31	Accrued Taxes Payable (excluding real estate taxes)	95,703		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,892		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Other Current Liabilities</u>	3,927,414		36
37	<u>3rd Party Payables/Cur Mat Lease</u>	40,747		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,002,910	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	12,437,101		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>LT Cap Lease, Net of Cur Maturity</u>	2,413		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 12,439,514	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 17,442,424	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,084,907	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 19,527,331	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 1,649,193	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 1,649,193	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	435,714	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 435,714	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 2,084,907	24 *

\* This must agree with page 17, line 47.

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 57,143,688	1
2	Discounts and Allowances for all Levels	(34,766,609)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 22,377,079</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	8
<b>C. Other Operating Revenue</b>			
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		13
14	Non-Patient Meals	88,432	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	34,400	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 122,832</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	21,008	24
25	Interest and Other Investment Income***	6,109	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 27,117</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Rental Income &amp; Misc</b>	(167)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ (167)</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 22,526,861</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,973,902	31
32	Health Care	12,908,254	32
33	General Administration	4,795,654	33
<b>B. Capital Expense</b>			
34	Ownership	2,413,337	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 22,091,147</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>435,714</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 435,714</b>	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	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$</b>	49

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

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

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

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

Facility Name & ID Number Mercy Harvard Hospital Care

# 8049116

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

**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	2,420	2,876	\$ 172,116	\$ 59.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	80,757	89,674	3,821,628	42.62	3
4	Licensed Practical Nurses	70	70	1,435	20.50	4
5	CNAs & Orderlies	30,395	33,526	499,437	14.90	5
6	CNA Trainees					6
7	Licensed Therapist	11,721	13,272	537,398	40.49	7
8	Rehab/Therapy Aides	640	727	14,877	20.46	8
9	Activity Director	1,865	2,123	34,962	16.47	9
10	Activity Assistants	1,930	2,149	34,140	15.89	10
11	Social Service Workers	1,904	2,080	56,313	27.07	11
12	Dietician	2,264	2,600	71,039	27.32	12
13	Food Service Supervisor	2,469	2,691	51,304	19.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,366	23,101	231,173	10.01	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	14,374	16,112	196,376	12.19	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	7,561	8,402	157,380	18.73	22
23	Office Manager					23
24	Clerical	12,289	13,590	229,185	16.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	208	208	40,195	193.25	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	9,294	10,896	219,219	20.12	31
32	Other Health C: Other Techs	51,101	57,525	1,793,573	31.18	32
33	Other(specify) <u>Patient Sitter</u>	7	7	64	9.14	33
34	TOTAL (lines 1 - 33)	252,635	281,629	\$ 8,161,814 *	\$ 28.98	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	648	\$ 35,585	10-3	50
51	Licensed Practical Nurses	740	35,759	10-3	51
52	Certified Nurse Assistants/Aides	1,154	33,746	10-3	52
53	TOTAL (lines 50 - 52)	2,542	\$ 105,090		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Clerical Staff	Clerk	0	\$ 54,535	Workers' Compensation Insurance	\$ 71,986	IDPH License Fee	\$	
				Unemployment Compensation Insurance	32,995	Advertising: Employee Recruitment		
				FICA Taxes	582,392	Health Care Worker Background Check		
				Employee Health Insurance	1,086,336	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Professional Mem & Dues	74,538	
				Life & Disability Insurance	50,652	Publications	2,316	
				Pension	268,253	Allocated to Non SNF areas	(37,191)	
				Employer TDA Match	71,614			
				Accrued Paid Leave	43,900			
				Employee Health & Other Benefits	5,621	Less: Public Relations Expense	( )	
				Allocated to Ancillary Cost Centers	(318,564)	Non-allowable advertising	( )	
				Allocated to Non SNF Areas	(1,521,737)	Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 54,535	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 373,448		\$ 39,663		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Hospital Assessment Tax			\$ 727,872			\$	Out-of-State Travel	\$
Memberships & Dues			56,698					
Admin Salaries/Interco Rent (net)			(7,412)					
Other Allocations			96,647				In-State Travel	28,345
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 873,805					
							Seminar Expense	
							Allocated to Non SNF Areas	(13,717)
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 12,715	TOTAL		\$	TOTAL	\$ 14,628

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Mercy Harvard Hospital Care# 8049116Report Period Beginning: 07/01/2013Ending: 06/30/2014**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?  
If YES, give association name and amount. No
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 8.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ Not Available Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 52,603  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 87,940
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: WIPFLI
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.