FOR BHF USE

LL1

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

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 8049116

Facility Name: Mercy Harvard Hospital Care

Address: 901 S Grant Box 850 (Number) Harvard (City) 60033 (Zip Code)

County: McHenry

Telephone Number: (608)755-5362 **Fax #** (608-741-7368

HFS ID Number:

Date of Initial License for Current Owners: 1954

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Tammy Jones **Telephone Number:** (608)755-5362 x5012
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2014 to 6/30/2015 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Katherine Kus
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	45	Skilled (SNF)	45	16,425	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	45	TOTALS	45	16,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,559	5,243	2,708	9,510	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,559	5,243	2,708	9,510	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.90%

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 [x]

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

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 [x] Date March 2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 34 and days of care provided 2,509

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 6/30/15 Fiscal Year: 6/30/15

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

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	375,953	33,882	145,124	554,959	(2,950)	552,009	(59,551)	492,458			1
2	Food Purchase											2
3	Housekeeping	178,081	17,929	36,746	232,757	(602)	232,155	(195,047)	37,108			3
4	Laundry		1,639	(1,714)	(75)		(75)	45	(30)			4
5	Heat and Other Utilities					321,374	321,374	(270,005)	51,369			5
6	Maintenance		1,105	879,676	880,781	(322,607)	558,174	(468,955)	89,219			6
7	Other (specify):* SPD & Light Duty	60,803	(456)	3,315	63,661		63,661	(6,868)	56,793			7
8	TOTAL General Services	614,837	54,099	1,063,148	1,732,084	(4,785)	1,727,299	(1,000,381)	726,918			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	5,401,419	1,211,948	2,703,072	9,316,439	(6,106,583)	3,209,856	(119,597)	3,090,259			10
10a	Therapy	468,887	11,978	45,074	525,939	(8,450)	517,489	(55,827)	461,662			10a
11	Activities											11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Rad, Lab, Pharm, PT	1,483,867	239,421	2,473,399	4,196,687	(4,196,687)	(0)		(0)			15
16	TOTAL Health Care and Programs	7,354,173	1,463,346	5,221,546	14,039,065	(10,311,720)	3,727,345	(175,424)	3,551,921			16
	C. General Administration											
17	Administrative	55,705	566	787,572	843,842	(145,002)	698,840	(575,378)	123,463			17
18	Directors Fees											18
19	Professional Services					15,400	15,400	(7,300)	8,100			19
20	Dues, Fees, Subscriptions & Promotions					92,920	92,920	(44,046)	48,874			20
21	Clerical & General Office Expenses	271,261	3,397	641,617	916,275	(5,455)	910,820	(431,747)	479,073			21
22	Employee Benefits & Payroll Taxes			2,195,456	2,195,456	(289,431)	1,906,025	(1,512,586)	393,439			22
23	Inservice Training & Education											23
24	Travel and Seminar					33,911	33,911	(16,075)	17,836			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			65,619	65,619	187,908	253,527	(219,013)	34,514			26
27	Other (specify):* Marketing, HR	8,635	1,088	286,236	295,959	(9,294)	286,665	(227,491)	59,174			27
28	TOTAL General Administration	335,601	5,051	3,976,500	4,317,152	(119,043)	4,198,109	(3,033,636)	1,164,473			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,304,611	1,522,496	10,261,194	20,088,301	(10,435,548)	9,652,753	(4,209,441)	5,443,312			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: 7/1/2014 Ending: 6/30/2015

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,695,471	1,695,471		1,695,471	(1,657,141)	38,330			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			571,356	571,356		571,356	(571,356)	(0)			32
33	Real Estate Taxes					57,510	57,510	(57,510)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					26,821	26,821	(14,963)	11,858			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,266,827	2,266,827	84,331	2,351,158	(2,300,970)	50,188			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					10,286,136	10,286,136	(10,286,136)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					65,081	65,081		65,081			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					10,351,217	10,351,217	(10,286,136)	65,081			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,304,611	1,522,496	12,528,021	22,355,128		22,355,128	(16,796,547)	5,558,581			45

***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: 7/1/2014 Ending: 6/30/2015

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (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 Yes	2 No	3 Amount	4 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	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Mercy Harvard Hospital Care

ID# 8049116

Report Period Beginning: 7/1/2014

Ending: 6/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Dietary Expense not related to SNF Care	$ (59,551)	1	1
2	Housekeeping Expenses not related to SNF Care	(195,047)	3	2
3	Laundry Expenses not related to SNF Care	45	4	3
4	Heat & Other Utilities not related to SNF Care	(270,005)	5	4
5	Maintenance Expenses not related to SNF Care	(468,955)	6	5
6	Central Supply Expense not related to SNF Care	(6,868)	7	6
7	Nursing & Medical Records Exp not related to SNF	(119,597)	10	7
8	Therapy Expenses not related to SNF Care	(55,827)	10a	8
9	Administrative Expenses not related to SNF Care	(575,378)	17	9
10	Professional Services not related to SNF Care	(7,300)	19	10
11	Dues, Fees & Subscriptions not related to SNF	(44,046)	20	11
12	Clerical & General Office Exp not related to SNF	(431,747)	21	12
13	Employee Ben & Payroll Taxes not related to SNF	(1,512,586)	22	13
14	Travel & Seminar Expense not related to SNF	(16,075)	24	14
15	Insurance Expenses not related to SNF Care	(219,013)	26	15
16	Human Res & Marketing Exp not related to SNF	(227,491)	27	16
17	Depreciation Expense not related to SNF Care	(1,657,141)	30	17
18	Interest Expense not related to SNF Care	(571,356)	32	18
19	Real Estate Taxes not related to SNF Care	(57,510)	33	19
20	Rent Expense - Equipment not related to SNF Care	(14,963)	35	20
21	Ancillary Services related to Acute - not SNF Oper	(10,286,136)	39	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(16,796,547)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Harvard Hospital Care **#** 8049116 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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	(59,551)	0	0	0	0	0	0	0	0	0	0	(59,551)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(195,047)	0	0	0	0	0	0	0	0	0	0	(195,047)	3
4	Laundry	45	0	0	0	0	0	0	0	0	0	0	45	4
5	Heat and Other Utilities	(270,005)	0	0	0	0	0	0	0	0	0	0	(270,005)	5
6	Maintenance	(468,955)	0	0	0	0	0	0	0	0	0	0	(468,955)	6
7	Other (specify):*	(6,868)	0	0	0	0	0	0	0	0	0	0	(6,868)	7
8	**TOTAL General Services**	(1,000,381)	0	0	0	0	0	0	0	0	0	0	(1,000,381)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(119,597)	0	0	0	0	0	0	0	0	0	0	(119,597)	10
10a	Therapy	(55,827)	0	0	0	0	0	0	0	0	0	0	(55,827)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(175,424)	0	0	0	0	0	0	0	0	0	0	(175,424)	16
	C. General Administration													
17	Administrative	(575,378)	0	0	0	0	0	0	0	0	0	0	(575,378)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,300)	0	0	0	0	0	0	0	0	0	0	(7,300)	19
20	Fees, Subscriptions & Promotions	(44,046)	0	0	0	0	0	0	0	0	0	0	(44,046)	20
21	Clerical & General Office Expenses	(431,747)	0	0	0	0	0	0	0	0	0	0	(431,747)	21
22	Employee Benefits & Payroll Taxes	(1,512,586)	0	0	0	0	0	0	0	0	0	0	(1,512,586)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(16,075)	0	0	0	0	0	0	0	0	0	0	(16,075)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(219,013)	0	0	0	0	0	0	0	0	0	0	(219,013)	26
27	Other (specify):*	(227,491)	0	0	0	0	0	0	0	0	0	0	(227,491)	27
28	**TOTAL General Administration**	(3,033,636)	0	0	0	0	0	0	0	0	0	0	(3,033,636)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,209,441)	0	0	0	0	0	0	0	0	0	0	(4,209,441)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(1,657,141)	0	0	0	0	0	0	0	0	0	0	(1,657,141)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(571,356)	0	0	0	0	0	0	0	0	0	0	(571,356)	32
33	Real Estate Taxes	(57,510)	0	0	0	0	0	0	0	0	0	0	(57,510)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(14,963)	0	0	0	0	0	0	0	0	0	0	(14,963)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,300,970)	0	0	0	0	0	0	0	0	0	0	(2,300,970)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(10,286,136)	0	0	0	0	0	0	0	0	0	0	(10,286,136)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(10,286,136)	0	0	0	0	0	0	0	0	0	0	(10,286,136)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(16,796,547)	0	0	0	0	0	0	0	0	0	0	(16,796,547)	45

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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
				Marcy Walworth Hosp	Walworth	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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 7/1/2014 Ending: 6/30/2015

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 [x] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	HoursWorked	50,848	3	$ 1,348,955	$ 1,348,955	8,490	$ 225,225	1
2	27	Merketing	HoursWorked	31,668	5	896,538	896,538	3,174	89,844	2
3	21	Information Systems	HoursWorked	185,309	4	6,385,688	6,385,688	2,612	90,000	3
4	21	Finance	HoursWorked	48,302	6	1,463,858	163,858	3,944	119,531	4
5	27	Human Resources	HoursWorked	44,748	4	1,366,917	1,366,917	2,064	63,035	5
6	21	Business Office	HoursWorked	219,653	2	3,607,488	3,607,488	13,430	220,569	6
7	17	Executive Salaries	HoursWorked	41,557	4	9,857,786	9,857,786	395	93,750	7
8	22	Pension Expense	Actual Expense	1	1	272,048	0	1	272,048	8
9	22	Worker's Comp	FTE's	3,149	5	1,619,722	73,081	142	73,081	9
10	26	Gen/Prof Liability Expense	Actual Expense	1	1	65,619	0	1	65,619	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					$ 26,884,619	$ 23,700,311		$ 1,312,702	25

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Mercy Alliance Loan	x		Hospital Renovations	Varies	2003	$ 5,570,000	$ 5,816,408			$ 276,279	1
2	Interentity Bond Payable 2012	x		Intercompany LT Payable	Varies	2012	6,650,805	6,605,637			291,956	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 12,220,805	$ 12,422,045			$ 568,235	9
	B. Non-Facility Related*											
10	Roche Diagnostics			Capital Lease	$168.00	2010	5,893	2,413	2016	0.0648	220	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$168.00		$ 5,893	$ 2,413			$ 220	14
15	TOTALS (line 9+line14)						$ 12,226,698	$ 12,424,458			$ 568,455	15

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

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

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

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2015 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. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

N/A - Hospital Property classified as not for profit - Tax Exempt

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

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

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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? [x] (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? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] 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

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5				SNF - Original building cannot be broken out from hospital building costs							5
6											6
7											7
8											8
	Improvement Type**										
9	Metal Lockers			1977	771		20			771	9
10	Door Alarm System			1990	1,055		10			1,055	10
11	Wiring for CC Phones			1990	418		10			418	11
12	Activities Office			1997	19,981		15			19,981	12
13	A/C Compressor			1996	1,922		30			1,922	13
14	Cabinets			1996	11,214	561	20	561		10,704	14
15	Wanderguard Unit			2000	2,652		10			2,652	15
16	Construct Firewall			2004	3,761	251	15	251	(0)	2,884	16
17	Skilled Care Nurse Station			2004	9,522	635	15	635	0	7,300	17
18	Top Upper Cabinet			2005	1,979	99	10	198	99	1,979	18
19	Care Center Wiring			2005	305		7			375	19
20	Patient Rooms			2007	20,000	2,000	10	2,000		17,000	20
21	Water Heater			2007	8,621	862	10	862		7,327	21
22	Care Center Circ Line Plumbing			2008	4,676	468	10	468	0	3,507	22
23	PT Wall Demo			2009	3,250	217	15	217	(0)	1,408	23
24	electrical Upgrade			2009	1,384	92	15	92	(0)	600	24
25	Network Drops			2009	555		5			555	25
26	LTC Driveway			2011	6,677	835	8	835	0	3,756	26
27	LTC Driveway			2011	9,660	644	15	644		2,898	27
28	LTC Roof			2011	17,724	1,772	10	1,772	0	7,976	28
29	Auto Entrance Doors			2011	4,493	449	10	449	0	2,022	29
30	HCC Dining Room Remodel			2014	95,000	6,333	15	6,333	0	9,500	30
31	Security Doors			2015	16,702	835	10	1,670	835	835	31
32	Manor Security System			2015	20,063	1,003	10	2,006	1,003	1,003	32
33	Security Doors			2015	2,411	121	10	241	121	121	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: 7/1/2014 Ending: 6/30/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	TOTAL (lines 4 thru 69)		$ 264,795	$ 17,176		$ 19,234	$ 2,058	$ 108,549	70

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

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	$ 239,424	$ 19,468	$ 19,468	$		$ 122,441	71
72	Current Year Purchases	34,942	1,265	1,265			1,265	72
73	Fully Depreciated Assets	170,231	421	421			170,231	73
74								74
75	TOTALS	$ 444,597	$ 21,154	$ 21,154	$		$ 293,937	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 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)	$ 712,845	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,330	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 40,388	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,058	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 402,486	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	$ 20,129,870	$ 797,050	$ 12,462,109	86
87	Equipment	13,863,474	832,406	10,085,771	87
88	Land Improvements	728,581	20,712	549,487	88
89					89
90					90
91	TOTALS	$ 34,721,925	$ 1,650,168	$ 23,097,367	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: 7/1/2014 Ending: 6/30/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: All rental equipment is short term rental

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 11,858 Description: Therapy Equip - $9,220.43, Copier - $1,220.40, Gas Cylinder - $1,417.19
(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.

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] 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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): N/A - All paid as staff wages									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 970,772	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,301,108)	3,838,554		3
4	Supply Inventory (priced at cost)	589,647		4
5	Short-Term Investments			5
6	Prepaid Insurance	87,193		6
7	Other Prepaid Expenses	173,333		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,659,498	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	951,185		13
14	Buildings, at Historical Cost	20,394,664		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	14,308,071		16
17	Accumulated Depreciation (book methods)	(23,499,782)		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): Unamortized Bond Fees	59,344		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,213,482	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 17,872,980	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 420,566	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	892,850		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,332		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,124		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Current Liabilities	1,969,421		36
37	Third Party Payables/Cur Mat Lease	284,913		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,623,206	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	12,422,045		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	LT Cap Lease (net of maturity)	497		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 12,422,542	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 16,045,748	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,827,232	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 17,872,980	$	48

***(See instructions.)**

Facility Name & ID Number Mercy Harvard Hospital Care **#** 8049116 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,084,907	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,084,907	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(257,675)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (257,675)	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)**	$ 1,827,232	24	*

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

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 59,579,373	1
2	Discounts and Allowances for all Levels	(37,600,396)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 21,978,977	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	94,358	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	5,781	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 100,139	23
	D. Non-Operating Revenue		
24	Contributions	14,123	24
25	Interest and Other Investment Income***	4,214	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,337	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)**	$ 22,097,453	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,978,872	31
32	Health Care	13,367,858	32
33	General Administration	4,741,571	33
	B. Capital Expense		
34	Ownership	2,266,827	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 22,355,128	40
41	**Income before Income Taxes (line 30 minus line 40)****	(257,675)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (257,675)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? 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: 7/1/2014 Ending: 6/30/2015

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,926	4,604	$ 290,291	$ 63.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	77,478	86,667	3,764,667	43.44	3
4	Licensed Practical Nurses	32	32	676	21.13	4
5	CNAs & Orderlies	31,249	34,956	529,082	15.14	5
6	CNA Trainees					6
7	Licensed Therapist	10,294	11,870	479,344	40.38	7
8	Rehab/Therapy Aides	1,650	1,696	30,882	18.21	8
9	Activity Director	1,866	2,129	35,705	16.77	9
10	Activity Assistants	1,945	2,088	34,417	16.48	10
11	Social Service Workers	1,876	2,080	57,908	27.84	11
12	Dietician	2,364	2,590	73,697	28.45	12
13	Food Service Supervisor	2,581	2,791	54,803	19.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,251	23,177	248,611	10.73	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	12,667	14,440	178,123	12.34	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	7,859	8,858	169,154	19.10	22
23	Office Manager					23
24	Clerical	12,215	13,883	244,645	17.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	208	208	55,156	265.17	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,922	8,854	194,163	21.93	31
32	Other Health C: Rad/Pharm	51,339	57,701	1,863,287	32.29	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	248,722	278,624	$ 8,304,611 *	$ 29.81	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,615	$ 88,114	10-3	50
51	Licensed Practical Nurses	836	39,281	10-3	51
52	Certified Nurse Assistants/Aides	886	24,722	10-3	52
53	TOTAL (lines 50 - 52)	3,337	$ 152,116		53

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Clerical Staff	Clerk	0	$ 55,705
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,705

B. Administrative - Other

Description	Amount
Hospital Assessment Tax	$ 464,111
Memberships & Dues	67,119
Admin Salaries (net of rent)	(9,448)
Other Allocations	265,790
TOTAL (agree to Schedule V, line 17, col. 3)	$ 787,572
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
WIPFLI	Cost Reports	$ 6,100
WIPFLI	Audit Fee	5,200
Baker Tilly	990 Prep	1,500
IL Charity Bureau	990 IL	15
IL Hospital Research & Educ	Mutual Assistance Program	1,085
Barbara Weiner	Legal Consult - General IL issue	1,500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 15,400

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,001
Unemployment Compensation Insurance	30,269
FICA Taxes	594,098
Employee Health Insurance	1,061,976
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life & Disability Insurance	44,251
Pension	272,648
Employer TDA Match	94,089
Accrued Paid Leave	19,314
Employee Health & Other Benefits	4,811
Allocated to Ancillary Cost Centers (col 5)	(289,431)
Allocated to Non SNF Areas (col 7)	(1,512,586)
TOTAL (agree to Schedule V, line 22, col.8)	$ 393,439

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Professional Memberships & Dues	91,383
Publications	1,537
Allocated to Non SNF areas	(44,046)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,874

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	33,911
Seminar Expense	
Allocated to Non SNF areas	(16,075)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,836

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
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 # 8049116 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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? **No**
If YES, give association name and amount.

(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? **12.5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** 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. $ **65,081**
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. $ **94,114**

(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. **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Legal Fees

Vendor	Date	Description of Services	Amount
Barbara A. Weiner	6/30/2014	Legal Consultation Program 8/1/14 - 7/31/15 (consultant for any IL specific issues)	$1,500.00

voting Members: 8
Independent members: 7

LIST OF OFFICERS, DIRECTORS, TRUSTEES AND PRINICPAL SALARIED EMPLOYEES
MERCY HARVARD HOSPITAL. #31-1551871
For the tax year: July 1, 2014 - June 30, 2015

NAME	TITLE	ADDRESS	COMPENSATION	CONTRIBUTION TO EMPLOYEE BENEFIT PLANS	DATE TERM ENDS
Kathy Schack Harvard, IL	Chairperson	21114 Robin Road Harvard, IL 60033	-0-	-0-	2016
Wesley Jost Woodstock, IL	Vice Chairperson	1103 Bayview Court Fox River Grove, IL 60021	-0-	-0-	2016
P. Casey Voris Crystal Lake, IL	Secretary/ Treasurer	81 Lincoln Parkway Crystal Lake, IL 60014	-0-	-0-	2017
Jeni Hallatt Lake Geneva, WI	Director	W3211 Lake Forest Lane Lake Geneva, WI 53147	-0-	-0-	Ex-Officio
Ron Kieras Woodstock, Il	Director	1609 South Valley Hill Rd Woodstock, Il 60098	-0-	-0-	2016
Carlos S. Arevalo Marengo, IL	Director	530 Locust St. Marengo, IL 60152	-0-	-0-	2015
Jay Schulz Harvard, IL	Director	1503 Pheasant Run Harvard, IL 60033	-0-	-0-	2017
Allen Castillo Woodstock, Il	Director	180 Prairie Ridge Dr. Woodstock, Il 60098	-0-	-0-	2017