FOR BHF USE

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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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0032680

Facility Name: Mercy Rehab and Care Center

Address: 100 Rosewood Vlg Dr (Number) Swansea (City) 62226 (Zip Code)

County: St Clair

Telephone Number: (618) 236-1391 **Fax #** (618) 236-9622

HFS ID Number:

Date of Initial License for Current Owners: 10/08/1987

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717
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 07/01/2015 to 06/30/2016 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) Paul Thonnard
(Title) President

Paid Preparer

(Signed) See Accountants' Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 E. Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

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**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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 _____

	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	120	Skilled (SNF)	120	43,920	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	120	TOTALS	120	43,920	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			6,373	6,373	8
9	SNF/PED					9
10	ICF	11,859	14,188	233	26,280	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,859	14,188	6,606	32,653	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.35%

D. How many bed-hold days during this year were paid by the Department?
None (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)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 10/08/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/08/1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 4,213

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 06/30/2016 Fiscal Year: 06/30/2016

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	256,317	26,260	9,704	292,281		292,281		292,281			1
2	Food Purchase		231,987		231,987		231,987	(3,257)	228,730			2
3	Housekeeping	166,721	35,196		201,917		201,917		201,917			3
4	Laundry	59,801	19,784		79,585		79,585		79,585			4
5	Heat and Other Utilities			138,941	138,941		138,941		138,941			5
6	Maintenance	54,107	13,398	150,160	217,665		217,665	75,004	292,669			6
7	Other (specify):* Waste Disposal			21,487	21,487		21,487		21,487			7
8	TOTAL General Services	536,946	326,625	320,292	1,183,863		1,183,863	71,747	1,255,610			8
	B. Health Care and Programs											
9	Medical Director			6,344	6,344		6,344		6,344			9
10	Nursing and Medical Records	2,267,015	182,803	181,335	2,631,153		2,631,153		2,631,153			10
10a	Therapy	115,672	1,164		116,836		116,836		116,836			10a
11	Activities	58,293	9,088	2,508	69,889		69,889		69,889			11
12	Social Services	66,653		2,308	68,961		68,961		68,961			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,507,633	193,055	192,495	2,893,183		2,893,183		2,893,183			16
	C. General Administration											
17	Administrative	89,870		240,000	329,870		329,870	(240,000)	89,870			17
18	Directors Fees											18
19	Professional Services			25,297	25,297		25,297	66,312	91,609			19
20	Dues, Fees, Subscriptions & Promotions			39,263	39,263	(706)	38,557	(7,023)	31,534			20
21	Clerical & General Office Expenses	246,101	33,087	94,158	373,346		373,346		373,346			21
22	Employee Benefits & Payroll Taxes			465,496	465,496		465,496		465,496			22
23	Inservice Training & Education											23
24	Travel and Seminar			686	686	706	1,392		1,392			24
25	Other Admin. Staff Transportation			9,594	9,594		9,594		9,594			25
26	Insurance-Prop.Liab.Malpractice			89,658	89,658		89,658	18,538	108,196			26
27	Other (specify):*											27
28	TOTAL General Administration	335,971	33,087	964,152	1,333,210		1,333,210	(162,173)	1,171,037			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,380,550	552,767	1,476,939	5,410,256		5,410,256	(90,426)	5,319,830			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 Rehab and Care Center #0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			28,876	28,876		28,876	25,556	54,432			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,764	5,764		5,764	447,124	452,888			32
33	Real Estate Taxes							69,488	69,488			33
34	Rent-Facility & Grounds			798,000	798,000		798,000	(798,000)				34
35	Rent-Equipment & Vehicles			33,231	33,231		33,231		33,231			35
36	Other (specify):*											36
37	**TOTAL Ownership**			865,871	865,871		865,871	(255,832)	610,039			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		247,439	748,983	996,422		996,422		996,422			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,880	226,880		226,880		226,880			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		247,439	975,863	1,223,302		1,223,302		1,223,302			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,380,550	800,206	3,318,673	7,499,429		7,499,429	(346,258)	7,153,171			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,257)	2		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	(1,587)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,526)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,537)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(857)	20		28
29	Other-Attach Schedule	(1,250)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,014)		$	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	(351,800)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (351,800)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (371,814)		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			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Mercy Rehab and Care Center

ID# 0032680

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Lobbying and Pac Dues	$ (3,240)	20	1
2	Add Back 1/2 of 2 yr IDPH license	1,990	20	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
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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**	(1,250)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Rehab and Care Center **#** 0032680 **Report Period Beginning:** 07/01/2015 **Ending:** 06/30/2016

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,257)	0	0	0	0	0	0	0	0	0	0	(3,257)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	75,004	0	0	0	0	0	0	0	0	0	75,004	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,257)	75,004	0	0	0	0	0	0	0	0	0	71,747	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(240,000)	0	0	0	0	0	0	0	0	0	(240,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,526)	72,838	0	0	0	0	0	0	0	0	0	66,312	19
20	Fees, Subscriptions & Promotions	(8,644)	1,621	0	0	0	0	0	0	0	0	0	(7,023)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	18,538	0	0	0	0	0	0	0	0	0	18,538	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(15,170)	(147,003)	0	0	0	0	0	0	0	0	0	(162,173)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,427)	(71,999)	0	0	0	0	0	0	0	0	0	(90,426)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 **Report Period Beginning:** 07/01/2015 **Ending:** 06/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	25,556	0	0	0	0	0	0	0	0	0	25,556	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,587)	448,711	0	0	0	0	0	0	0	0	0	447,124	32
33	Real Estate Taxes	0	69,488	0	0	0	0	0	0	0	0	0	69,488	33
34	Rent-Facility & Grounds	0	(798,000)	0	0	0	0	0	0	0	0	0	(798,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,587)	(254,245)	0	0	0	0	0	0	0	0	0	(255,832)	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(20,014)	(326,244)	0	0	0	0	0	0	0	0	0	(346,258)	45

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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
Rosewood Care Center Holding Co.	100	N/A		SILDA LLC	St. Louis, MO	Real Estate Lsg.
				HSM Venture	St. Louis, MO	Management Co.

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. [X] 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	34	Rent	$ 798,000	SILDA LLC		$	$ (798,000)	1
2	V	6	Maintenance		SILDA LLC		75,004	75,004	2
3	V	26	Property Insurance		SILDA LLC		18,538	18,538	3
4	V	30	Depreciation		SILDA LLC		25,556	25,556	4
5	V	32	Interest		SILDA LLC		445,379	445,379	5
6	V	33	Real Estate Taxes		SILDA LLC		69,488	69,488	6
7	V								7
8	V	17	Administrative	240,000	HSM Venture			(240,000)	8
9	V	19	Professional Services		HSM Venture		72,838	72,838	9
10	V	20	Dues, Fees and Licenses		HSM Venture		1,621	1,621	10
11	V	32	Interest		HSM Venture		3,332	3,332	11
12	V								12
13	V								13
14	Total			$ 1,038,000			$ 711,756	$ * (326,244)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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20								20
21								21
22								22
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25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	Schedule 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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 6/30/2016

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	St. Louis Bank		X	Mortgage	$65,394.00	08/28/15	$ 13,600,000	$ 12,183,348	08/28/18	4.0000	$ 445,379	1
2												2
3												3
4												4
5												5
	Working Capital											
6				Miscellaneous							5,764	6
7				Management Company							3,332	7
8												8
9	TOTAL Facility Related				$65,394.00		$ 13,600,000	$ 12,183,348			$ 454,475	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13				Interest Income							(1,587)	13
14	TOTAL Non-Facility Related						$	$			$ (1,587)	14
15	TOTALS (line 9+line14)						$ 13,600,000	$ 12,183,348			$ 452,888	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' PREPARATION REPORT

** 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 Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	66,507	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.)	$	66,995	2
3. Under or (over) accrual (line 2 minus line 1).	$	488	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	71,000	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.)	$	(2,000)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	69,488	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	65,275	8
	2012	63,511	9
	2013	63,080	10
	2014	64,735	11
	2015	69,254	12

Line 2: 2nd installment of 2014 taxes $32,368 and 1st installment of 2015 taxes $34,627 = $66,995 paid

Line 4: 1/2 of the 2015 taxes due, plus 1/2 of the estimated 2016 taxes due.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mercy Rehab and Care Center COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0032680

CONTACT PERSON REGARDING THIS REPORT Cindy Tefteller

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-09.0-402-023	Wandering Woods	$ 69,253.74	$ 69,253.74
2.		Lot/SEC-3 A02410700	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,253.74	$ 69,253.74

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,331 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (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).

None

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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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	Nursing Home	6.8097 Acres	1987	$ 126,031	1
2					2
3	TOTALS	#VALUE!		$ 126,031	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	102			1987	$ 2,175,969	$	20 - 25	$	$	$ 2,175,969	4
5	10			1988	253,539		25			253,539	5
6	8			1990	222,972		25	2,707	2,707	222,972	6
7				1991	6,679		25	267	267	6,610	7
8											8
	Improvement Type**										
9	Walk In Cooler			1987	5,515		10			5,515	9
10	Exhaust Hood			1987	6,498		10			6,498	10
11	Paging Systems			1987	632		10			632	11
12	Carpet			1987	39,910		10			39,910	12
13	Hospital Track/Curtain			1987	8,075		10			8,075	13
14	Signs			1987	2,916		10			2,916	14
15	Telephone Equipment			1987	3,180		10			3,180	15
16	Outside Sign			1987	4,504		10			4,504	16
17	Water Heater			1987	3,650		10			3,650	17
18	Walk In Freezer			1988	3,936		15			3,936	18
19	Nurse Call System			1988	670		15			670	19
20	Sign			1989	2,000		10			2,000	20
21	Exhaust Fan			1989	530		10			530	21
22	Water Treatment System			1989	5,905		10			5,905	22
23	Door Guards			1989	5,509		10			5,509	23
24	Corner Guards			1990	1,446		10			1,446	24
25	Carpeting			1990	2,215		10			2,215	25
26	Hot Water Storage			1996	2,607		10			2,607	26
27	Landscaping/Fencing			1987	25,279		25			25,279	27
28	Water Hydrant			1988	1,677		10			1,677	28
29	Trees and Seeding			1988	745		10			745	29
30	Seeding			1988	4,290		10			4,290	30
31	Parking Lot Expansion			1988	621		25			621	31
32	Road			1990	431,970		25			431,970	32
33	Parking Lot Expansion			1989	27,592		15			27,592	33
34	Landscaping			1989	1,904		25			1,904	34
35	Lawn Sprinkler System			1992	10,926		25	437	437	10,380	35
36	Backflow for Sprinkler			1993	2,909		25	116	116	2,692	36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	Sinks	1987	$ 4,156	$	10	$	$	$ 4,156	37
38	Hand Sinks	1987	181		10			181	38
39	Heat Pumps	2003	3,746		10			3,746	39
40	Roof Work	2004	21,620		40	541	541	6,486	40
41	Storage Building	2004	13,980		25	559	559	6,524	41
42	Parking Lot Seal & Stripe	2004	3,993		2			3,993	42
43	Telephone Power Pole	2005	10,875		10	91	91	10,875	43
44	Fire Alarm System	2005	9,668		10	242	242	9,668	44
45	Satellite System	2006	9,002		10	675	675	9,002	45
46	Heat Pumps	2007	37,285		10	3,729	3,729	34,313	46
47	Evaporative Cooling Tower	2007	48,252		10	4,825	4,825	44,231	47
48	Water Heater	2007	3,545		10	355	355	3,131	48
49	Compressor Blower Motor	2007	2,938		10	294	294	2,619	49
50	Water Heater	2007	3,595		10	359	359	3,145	50
51	Electrical Wiring	2009	3,153		10	315	315	2,338	51
52	Painting Exterior Building	2010	8,792		40	220	220	1,337	52
53	Heat Pumps	2009	6,327		10	633	633	4,218	53
54	Exterior Doors	2009	9,014		10	901	901	6,009	54
55	Wall Cabinets	2009	1,009		10	101	101	673	55
56	Sprinkler Pipe	2010	14,909		10	1,491	1,491	9,318	56
57	Water Heater	2010	4,040		10	404	404	2,491	57
58	Cooling Tower Fan	2011	4,554		10	455	455	2,315	58
59	Seal & Stripe Parking Lot	2010	4,839		25	194	194	1,097	59
60	Heat Pumps	2012	5,218		10	522	522	2,261	60
61	Replace Interior/Exterior Doors	2013	6,951		10	695	695	2,143	61
62	Purchase & Install 8 Doors	2013	3,476		40	87	87	241	62
63	Water Heater	2015	6,699		10	670	670	837	63
64	A/C's/Heat Pumps	2015	5,310		10	531	531	752	64
65	Landscaping	2013	3,310		25	132	132	353	65
66	Landscaping	2015	5,375		25	215	215	215	66
67	A/C Units	2015	14,019		10	1,285	1,285	1,285	67
68	3 Heat Pumps	2016	8,240		10	275	275	275	68
69	Cooling Tower Coil	2016	29,740		10	248	248	248	69
70	TOTAL (lines 4 thru 69)		$ 3,584,581	$		$ 24,571	$ 24,571	$ 3,446,414	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	
1	Totals from Page 12A, Carried Forward		$ 3,584,581	$		$ 24,571	$ 24,571	$ 3,446,414	1
2	7 A/C Units	2016	17,813		10				2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10	Leasehold Improvements paid for by the Lessee:								10
11	Carpet/Tile/Painting - Nurse Call Station	1993	20,471		7			20,471	11
12	Painting/Wallpaper	1994	15,422		7			15,422	12
13	Painting/Wallpaper/Tile	1995	25,375		7			25,375	13
14	Shelving	1995	2,186		7			2,186	14
15	New Upholstery	1995	513		7			513	15
16	Design Work	1995	128		7			128	16
17	Carpeting	1996	5,580		7			5,580	17
18	Painting/Tiling	1996	6,383		7			6,383	18
19	Painting	1997	3,025		7			3,025	19
20	Tile & Base 2 Rooms	1997	1,400		7			1,400	20
21	2 Oak Doors	1997	803		7			803	21
22	Carpet & Installation	1998	7,951		7			7,951	22
23	Shower Renovations	1998	16,869		7			16,869	23
24	Paint/Wallpaper/Tile Removal	1998	1,833		7			1,833	24
25	Shower Room	1998	18,424		7			18,424	25
26	Wallpaper	1999	273		7			273	26
27	Painting	1998	970		7			970	27
28	Wallpaper	1998	5,103		7			5,103	28
29	Carpet/Installation	1998	5,106		7			5,106	29
30	Phone System	1998	8,703		7			8,703	30
31	Wallpaper	1998	4,450		7			4,450	31
32	Drapery	2000	31,964		7			31,964	32
33	Computer Cabling	2000	2,392		7			2,392	33
34	TOTAL (lines 1 thru 33)		$ 3,787,718	$		$ 24,571	$ 24,571	$ 3,631,738	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	
1	Totals from Page 12B, Carried Forward		$ 3,787,718	$		$ 24,571	$ 24,571	$ 3,631,738	1
2	Painting	2001	18,240		7			18,240	2
3	Cabling	2001	606		7			606	3
4	Carpet	2002	1,150		7			1,150	4
5	Wallcovering	2004	3,554		7			3,554	5
6	Drywall	2004	6,594		7			6,594	6
7	Shelving	2004	2,271		7			2,271	7
8	Tile & Base 2 Rooms	2004	5,918		7			5,918	8
9	Floor Tile & Base	2005	4,203		7			4,203	9
10	Parking Lot Striping & Sealing	2005	3,993		7			3,993	10
11	Repair Water Damaged Rooms	2005	6,141		7			6,141	11
12	Drapes	2006	4,666		7			4,666	12
13	Carpet	2009	13,379	956	7	956		12,742	13
14	Water Heater	2011	4,780	684	7	684		3,245	14
15	Telephone System	2011	27,729	3,961	7	3,961		18,841	15
16	Cooling Tower Fan Motor Repair	2011	4,554	652	7	652		3,255	16
17	3 Door Freezer	2011	5,056	722	7	722		3,611	17
18	Flooring - 400, 500 corridors, 100/200 & 400/500 nurses station	2013	4,916	702	7	702		2,223	18
19	main & assisted dining rooms, mechanical wing, therapy wing								19
20	500 corridor bathing suite, rooms 501, 503, 402, 404, 516, & 517								20
21	Lobby Floor	2014	2,200	314	7	314		523	21
22	Lobby Walls	2014	3,400	486	7	486		729	22
23	Parking Lot Paved	2015	4,980	712	7	712		712	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,916,048	$ 9,189		$ 33,760	$ 24,571	$ 3,734,955	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	$ 97,406	$ 12,690	$ 13,592	$ 902	7 & 10	$ 39,597	71
72	Current Year Purchases	9,376	1,743	1,826	83	10	1,826	72
73	Fully Depreciated Assets	391,039					391,039	73
74								74
75	TOTALS	$ 497,821	$ 14,433	$ 15,418	$ 985		$ 432,462	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	Facility Use	2014 Bus	2014	$ 36,777	$ 5,254	$ 5,254	$	7	$ 8,757	76
77										77
78										78
79										79
80	TOTALS			$ 36,777	$ 5,254	$ 5,254	$		$ 8,757	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)	$ 4,576,677	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,876	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 54,432	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 25,556	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,176,174	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	Section N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Major Remodel Project	$ 38,571	92
93			93
94			94
95		$ 38,571	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule N/A

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ Description:
(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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	10a, 2	hrs				1,164		1,164	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				247,439		247,439	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): PT, OT, ST, Lab, Xray	39, 3				748,983			748,983	13
14	TOTAL			$		$ 748,983	$ 248,603		$ 997,586	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.

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Mercy Rehab and Care Center **#** 0032680 **Report Period Beginning:** 07/01/2015 **Ending:** 06/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2016 **(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	$ 333,261	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	1,190,721		3
4	Supply Inventory (priced at)	5,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	40,646		6
7	Other Prepaid Expenses	33,542		7
8	Accounts Receivable (owners or related parties)	27,792		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,630,962	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	313,654		15
16	Equipment, at Historical Cost	131,552		16
17	Accumulated Depreciation (book methods)	(332,146)		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): Deposits	2,467		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 115,527	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,746,489	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 218,457	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	198,770		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,238		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	52,769		36
37	Note Payable - Related Party	200,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 679,234	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Chapter 11 Settlement Payable	2,872		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,872	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 682,106	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,064,383	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,746,489	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,273,235	1
2	Restatements (describe):		2
3	**Depreciation Adjustment**	13	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,273,248	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(158,865)	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	(50,000)	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)**	$ (208,865)	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)**	$ 1,064,383	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	$ 7,517,594	1
2	Discounts and Allowances for all Levels	(1,545,955)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,971,639	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,364,118	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,364,118	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	3,300	13
14	Non-Patient Meals	3,257	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		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,557	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,587	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,587	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	529	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 529	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,344,430	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,183,863	31
32	Health Care	2,893,183	32
33	General Administration	1,333,210	33
	B. Capital Expense		
34	Ownership	865,871	34
	C. Ancillary Expense		
35	Special Cost Centers	996,422	35
36	Provider Participation Fee	226,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,499,429	40
41	**Income before Income Taxes (line 30 minus line 40)****	(154,999)	41
42	**Income Taxes**	(3,866)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (158,865)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,760,749	44
45	Private Pay - Net Inpatient Revenue	2,583,764	45
46	Medicare - Net Inpatient Revenue	1,239,962	46
47	Other-(specify) Managed Care/Private Insurance	387,164	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,971,639	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	1,510	1,631	$ 66,187	$ 40.58	1
2	Assistant Director of Nursing	1,678	1,812	66,791	36.86	2
3	Registered Nurses	16,155	17,442	510,926	29.29	3
4	Licensed Practical Nurses	27,765	29,976	650,240	21.69	4
5	CNAs & Orderlies	77,554	83,731	915,903	10.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,418	5,849	115,672	19.78	8
9	Activity Director					9
10	Activity Assistants	4,973	5,370	58,293	10.86	10
11	Social Service Workers	3,682	3,975	66,653	16.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,400	24,184	256,317	10.60	15
16	Dishwashers					16
17	Maintenance Workers	2,498	2,697	54,107	20.06	17
18	Housekeepers	14,416	15,564	166,721	10.71	18
19	Laundry	5,715	6,170	59,801	9.69	19
20	Administrator	1,757	1,897	89,870	47.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,324	14,385	246,101	17.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,424	3,697	56,968	15.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	202,269	218,380	$ 3,380,550 *	$ 15.48	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	Contract	$ 9,704	1, 3	35
36	Medical Director	Contract	6,344	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,134	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	2,508	11, 3	44
45	Social Service Consultant	Contract	2,308	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 21,998		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	750	$ 29,668	10, 3	50
51	Licensed Practical Nurses	1,400	42,085	10, 3	51
52	Certified Nurse Assistants/Aides	5,400	108,448	10, 3	52
53	TOTAL (lines 50 - 52)	7,550	$ 180,201		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gail Kimmle	Administrator	0	$ 89,870
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,870

B. Administrative - Other

Description	Amount
Management Fee - HSM Venture	$ 240,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 240,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Daniel Maker	Non-allowable Legal Fees	$ 6,526
Clifton, Larson, Allen	Accounting/Consulting	2,460
SJM & Co	Accounting/Consulting	1,380
Saric Consulting	Medicaid Consulting	207
First Advantage Tax Consulting	Accounting/Consulting	1,885
Summers, Compton, Wells	Legal Fees	376
C.J. Schlosser & Company	Accounting/Consulting	12,463
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 25,297

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,815
Unemployment Compensation Insurance	48,259
FICA Taxes	252,078
Employee Health Insurance	52,484
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Drug Tests and Physicals	2,050
Uniforms	1,369
Employee Relations	3,441
TOTAL (agree to Schedule V, line 22, col.8)	$ 465,496

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	14,574
Health Care Worker Background Check	
(Indicate # of checks performed)	5,914
Patient Background Checks	
IHCA Allowable Fees	4,320
Licenses & Fees	2,940
Other Dues & Subscriptions	175
Home Office Licenses & Fees	1,621
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,534

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	686
Seminar Expense	706
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,392

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4,320**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **N/A**

(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? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **59,263** Line **10**

(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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **226,880**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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? **N/A**

(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. $ **3,257**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(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