

Facility Name & ID Number Mercy Harvard Hospital Care

8049116 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 45

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>45</u>	Skilled (SNF)	<u>45</u>	<u>16,425</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>45</u>	TOTALS	<u>45</u>	<u>16,425</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	<u>1,457</u>	<u>4,984</u>	<u>2,579</u>	<u>9,020</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,457</u>	<u>4,984</u>	<u>2,579</u>	<u>9,020</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.92%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Meals on Wheels, Employee Meals

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 1976

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 34 and days of care provided 1,945

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/17 Fiscal Year: 6/30/17

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

Facility Name & ID Number Mercy Harvard Hospital Care # 8049116 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	410,166	24,405	133,882	568,454	(2,025)	566,428	(63,439)	502,989		1
2	Food Purchase										2
3	Housekeeping	191,615	20,898	41,958	254,471	(3,136)	251,335	(211,162)	40,173		3
4	Laundry		1,454	-2,040	(586)		(586)	334	(252)		4
5	Heat and Other Utilities					292,539	292,539	(245,779)	46,760		5
6	Maintenance		1,415	647,987	649,402	(295,561)	353,842	(297,283)	56,559		6
7	Other (specify):*	63,359	5,198	4,797	73,354		73,354	(8,216)	65,138		7
8	TOTAL General Services	665,141	53,370	826,584	1,545,095	(8,182)	1,536,912	(825,545)	711,367		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	5,827,561	990,101	3,073,231	9,890,893	(6,692,003)	3,198,890	(130,385)	3,068,505		10
10a	Therapy	420,345	17,972	56,871	495,188	(14,477)	480,711	(53,839)	426,872		10a
11	Activities										11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*	1,464,446	254,972	2,557,997	4,277,415	(4,277,415)	(0)		(0)		15
16	TOTAL Health Care and Programs	7,712,352	1,263,044	5,688,099	14,663,495	(10,983,895)	3,679,601	(184,224)	3,495,377		16
	C. General Administration										
17	Administrative	58,281	1,095	724,971	784,347	(147,700)	636,647	(579,223)	57,425		17
18	Directors Fees										18
19	Professional Services					15,807	15,807	(7,525)	8,282		19
20	Dues, Fees, Subscriptions & Promotions					92,735	92,735	(44,149)	48,586		20
21	Clerical & General Office Expenses	231,602	2,294	604,108	838,004	52,154	890,158	(423,786)	466,372		21
22	Employee Benefits & Payroll Taxes			2,452,606	2,452,606	(323,664)	2,128,942	(1,701,353)	427,589		22
23	Inservice Training & Education										23
24	Travel and Seminar					32,984	32,984	(15,703)	17,281		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			52,432	52,432	202,631	255,063	(227,593)	27,470		26
27	Other (specify):*	9,630	1,068	290,466	301,164	(2,963)	298,201	(238,308)	59,893		27
28	TOTAL General Administration	299,513	4,456	4,124,584	4,428,553	(78,015)	4,350,538	(3,237,640)	1,112,898		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,677,006	1,320,871	10,639,266	20,637,143	(11,070,093)	9,567,051	(4,247,409)	5,319,642		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:

7/1/2016

Ending:

6/30/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			1,681,276	1,681,276		1,681,276	(1,638,830)	42,446			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			315,732	315,732		315,732	(315,732)	(0)			32
33	Real Estate Taxes					55,530	55,530	(55,530)	0			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					18,810	18,810	(13,994)	4,816			35
36	Other (specify):*											36
37	TOTAL Ownership			1,997,008	1,997,008	74,340	2,071,348	(2,024,086)	47,262			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					8,390	8,390		8,390			38
39	Ancillary Service Centers					10,915,985	10,915,985	(10,915,985)	(0)			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					71,377	71,377		71,377			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					10,995,752	10,995,752	(10,915,985)	79,767			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,677,006	1,320,871	12,636,274	22,634,151	(0)	22,634,151	(17,187,480)	5,446,671			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		See Schedule	15	42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule	X		See Schedule	10,15,22	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Mercy Harvard Hospital Care

ID# 8049116

Report Period Beginning: 7/1/2016

Ending: 6/30/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Dietary Expense not related to SNF Care	\$ (63,439)	1	1
2	Housekeeping Expenses not related to SNF Care	(211,162)	3	2
3	Laundry Expenses not related to SNF Care	334	4	3
4	Heat & Other Utilities not related to SNF Care	(245,779)	5	4
5	Maintenance Expenses not related to SNF Care	(297,283)	6	5
6	Central Supply Expense not related to SNF Care	(8,216)	7	6
7	Nursing & Medical Records Exp not related to SNF	(130,385)	10	7
8	Therapy Expenses not related to SNF Care	(53,839)	10a	8
9	Administrative Expenses not related to SNF Care	(579,223)	17	9
10	Professional Services not related to SNF Care	(7,525)	19	10
11	Dues, Fees & Subscriptions not related to SNF	(44,149)	20	11
12	Clerical & General Office Exp not related to SNF	(423,786)	21	12
13	Employee Ben & Payroll Taxes not related to SNF	(1,701,353)	22	13
14	Travel & Seminar Expense not related to SNF	(15,703)	24	14
15	Insurance Expenses not related to SNF Care	(227,593)	26	15
16	Human Res & Marketing Exp not related to SNF	(238,308)	27	16
17	Depreciation Expense not related to SNF Care	(1,638,830)	30	17
18	Interest Expense not related to SNF Care	(315,732)	32	18
19	Real Estate Taxes not related to SNF Care	(55,530)	33	19
20	Rent Expense - Equipment not related to SNF Care	(13,994)	35	20
21	Ancillary Services related to Acute - not SNF Oper	(10,915,985)	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	(17,187,480)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Harvard Hospital Care# 8049116 Report Period Beginning:

7/1/2016

Ending: 6/30/2017

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	(63,439)	0	0	0	0	0	0	0	0	0	0	(63,439)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	(211,162)	0	0	0	0	0	0	0	0	0	0	(211,162)	3
4	Laundry	334	0	0	0	0	0	0	0	0	0	0	334	4
5	Heat and Other Utilities	(245,779)	0	0	0	0	0	0	0	0	0	0	(245,779)	5
6	Maintenance	(297,283)	0	0	0	0	0	0	0	0	0	0	(297,283)	6
7	Other (specify):*	(8,216)	0	0	0	0	0	0	0	0	0	0	(8,216)	7
8	TOTAL General Services	(825,545)	0	0	0	0	0	0	0	0	0	0	(825,545)	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	(130,385)	0	0	0	0	0	0	0	0	0	0	(130,385)	10
10a	Therapy	(53,839)	0	0	0	0	0	0	0	0	0	0	(53,839)	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	(184,224)	0	0	0	0	0	0	0	0	0	0	(184,224)	16
	C. General Administration													
17	Administrative	(579,223)	0	0	0	0	0	0	0	0	0	0	(579,223)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,525)	0	0	0	0	0	0	0	0	0	0	(7,525)	19
20	Fees, Subscriptions & Promotions	(44,149)	0	0	0	0	0	0	0	0	0	0	(44,149)	20
21	Clerical & General Office Expenses	(423,786)	0	0	0	0	0	0	0	0	0	0	(423,786)	21
22	Employee Benefits & Payroll Taxes	(1,701,353)	0	0	0	0	0	0	0	0	0	0	(1,701,353)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(15,703)	0	0	0	0	0	0	0	0	0	0	(15,703)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(227,593)	0	0	0	0	0	0	0	0	0	0	(227,593)	26
27	Other (specify):*	(238,308)	0	0	0	0	0	0	0	0	0	0	(238,308)	27
28	TOTAL General Administration	(3,237,640)	0	0	0	0	0	0	0	0	0	0	(3,237,640)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,247,409)	0	0	0	0	0	0	0	0	0	0	(4,247,409)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mercy Harvard Hospital Care# 8049116

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,638,830)	0	0	0	0	0	0	0	0	0	0	(1,638,830)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(315,732)	0	0	0	0	0	0	0	0	0	0	(315,732)	32
33	Real Estate Taxes	(55,530)	0	0	0	0	0	0	0	0	0	0	(55,530)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(13,994)	0	0	0	0	0	0	0	0	0	0	(13,994)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,024,086)	0	0	0	0	0	0	0	0	0	0	(2,024,086)	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	(10,915,985)	0	0	0	0	0	0	0	0	0	0	(10,915,985)	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	(10,915,985)	0	0	0	0	0	0	0	0	0	0	(10,915,985)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(17,187,480)	0	0	0	0	0	0	0	0	0	0	(17,187,480)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mercy Health System	100			Mercy Hospital	Janesville	Hospital
				Mercy Home Health	Janesville	Includes Homecare
				Mercy Health		Parent
				Mercy Walworth Hosp	Lake Geneva	Hospital

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V			n/a				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:

7/1/2016

Ending:

6/30/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Mercy Harvard Hospital Care

#

8049116

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	n/a								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Mercy Harvard Hospital Care

8049116

Report Period Beginning:

7/1/2016

Ending: 5/30/2017

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization Mercy Health
 Street Address 100 Mineral Point
 City / State / Zip Code Janesville, WI 53545
 Phone Number (608-755-5362 ext 2082
 Fax Number (608-741-7368

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	Hours Worked	46,652	3	\$ 1,177,084	\$ 1,177,084	7,209	\$ 181,894	1
2	27	Marketing	Hours Worked	27,290	5	689,117	689,177	2,985	75,367	2
3	21	Information Systems	Hours Worked	177,677	4	5,983,034	5,983,034	2,306	77,649	3
4	21	Finance	Hours Worked	40,599	6	1,057,163	1,057,163	3,126	81,395	4
5	27	Human Resources	Hours Worked	39,555	4	1,022,687	1,022,687	2,427	62,752	5
6	21	Business Office	Hours Worked	213,503	2	3,481,851	3,481,851	18,207	296,923	6
7	17	Executive Salaries	Hours Worked	41,017	4	7,126,985	7,126,985	465	80,738	7
8	22	Pension Expense	Actual Expense	1	1	144,306	0	1	144,306	8
9	22	Workers Comp	FTEs	5,701	5	1,811,259	73,877	143	45,355	9
10	26	Gen/Prof Liability Exp	Actual Expense	1	1	52,432	0	1	52,432	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 22,545,918	\$ 20,611,858		\$ 1,098,811	25

Facility Name & ID Number

Mercy Harvard Hospital Care

8049116

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Mercy Alliance Loan	X		Hospital Renovations	varies	2003	\$ 5,570,000					\$ 20,752	1					
2	Interentity Bond Payable 2012	X		Intercompany LT Payable	varies	2012	6,650,805	6,512,790				291,956	2					
3													3					
4													4					
5													5					
Working Capital																		
6													6					
7													7					
8													8					
9	TOTAL Facility Related						\$ 12,220,805	\$ 6,512,790				\$ 312,708	9					
B. Non-Facility Related*																		
10	Roche Diagnostics			capital lease	\$168.00	2010	5,893			2016	0.6480	7	10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related				\$168.00		\$ 5,893					\$ 7	14					
15	TOTALS (line 9+line14)						\$ 12,226,698	\$ 6,512,790				\$ 312,715	15					

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2016 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 2017 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:	2012	8	
	2013	9	
	2014	10	
	2015	11	
	2016	12	
N/A - Hospital property classified as not-for-profit - tax exempt			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2016 \$	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.

2016 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 2016 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 2016.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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:

7/1/2016

Ending:

6/30/2017

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).

Blank lines for listing other business entities.

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.

Table with 4 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost. Row 1: Hospital/SNF, 85,800, 1954, \$ 3,452. Row 2: (blank), (blank), (blank), (blank). Row 3: TOTALS, 85,800, (blank), \$ 3,452.

Facility Name & ID Number Mercy Harvard Hospital Care

8049116

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Metal Lockers	1977		771		20			771	9
10		Door Alarm System	1990		1,055		10			1,055	10
11		Wiring for CC Phones	1990		418		10			418	11
12		Activities Office	1997		19,981		15			19,981	12
13		A/C Compressor	1996		1,922		30			1,922	13
14		Cabinets	1996		11,214	229	20	561	331	11,214	14
15		Wanderguard Unit	2000		2,652		10			2,652	15
16		Construct Firewall	2004		3,761	251	15	251	(0)	3,385	16
17		Skilled Care Nurse Station	2004		9,522	635	15	635	0	8,569	17
18		Top Upper Cabinet	2005		1,979		10			1,979	18
19		Care Center Wiring	2005		305		7			305	19
20		Patient Rooms	2007		20,000	1,000	10	2,000	1,000	20,000	20
21		Water Heater	2007		8,621	431	10	862	431	8,621	21
22		Care Center Circ Line Plumbing	2008		4,676	468	10	468	0	4,442	22
23		PT Wall Demo	2009		3,250	217	15	217	(0)	1,842	23
24		electrical Upgrade	2009		1,384	92	15	92	(0)	784	24
25		Network Drops	2009		555		5			555	25
26		LTC Driveway	2011		6,677	835	8	835	0	5,425	26
27		LTC Driveway	2011		9,660	644	15	644		4,186	27
28		LTC Roof	2011		17,724	1,772	10	1,772	0	11,520	28
29		Auto Entrance Doors	2011		4,493	449	10	449	0	2,921	29
30		HCC Dining Room Remodel	2014		95,000	6,333	15	6,333	0	22,167	30
31		Security Doors	2015		16,702	1,670	10	1,670	(0)	4,176	31
32		Manor Security System	2015		20,063	2,006	10	2,006	0	5,016	32
33		Security Doors	2015		2,411	241	10	241	0	603	33
34		Replace Windows in Care Center	2016		9,795	980	10	980		1,469	34
35		Replace Broken Windows in Care Center	2016		3,399	340	10	340		510	35
36		Auto Doors at Care Center	2017		9,699	489	10	970		489	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:

7/1/2016

Ending:

6/30/2017

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Nurse Call System	2017	\$ 79	\$ 4	10	\$ 8	\$ 4	\$ 4	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 287,767	\$ 19,086		\$ 21,333	\$ 1,766	\$ 146,980	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:

7/1/2016

Ending:

6/30/2017

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	\$ 261,137	\$ 20,639	\$ 20,639	\$		\$ 126,705	71
72	Current Year Purchases	55,041	2,865	2,865			2,865	72
73	Fully Depreciated Assets	212,614	1,713	1,713			212,614	73
74								74
75	TOTALS	\$ 528,791	\$ 25,217	\$ 25,217	\$		\$ 342,184	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)	\$ 820,011	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 44,303	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,550	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,247	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 489,164	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	\$ 20,475,099	\$ 760,884	\$ 14,001,597	86
87	Equipment	14,572,367	845,613	11,788,779	87
88	Land Improvements	807,429	30,478	605,895	88
89					89
90					90
91	TOTALS	\$ 35,854,895	\$ 1,636,975	\$ 26,396,271	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: All Rental Equip is short-term rental

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,816 Description: Therapy Equipment \$3,971, Copier \$845

(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.

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.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.

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

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 797,865	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>11,343,702</u>)	576,850		3
4	Supply Inventory (priced at)	887,980		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	170,650		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>other current receivables</u>	154,705		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,588,050	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,030,033		13
14	Buildings, at Historical Cost	20,762,866		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	15,101,158		16
17	Accumulated Depreciation (book methods)	(26,885,434)		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 (spe <u>CIP</u>)	2,500		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,011,122	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,599,172	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 239,739	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	726,580		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,312		31
32	Accrued Real Estate Taxes(Sch.IX-B)	29,179		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Current Liabilities</u>	183,138		36
37	<u>Third Party Payables/Cur Mat Lease</u>	860,549		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,040,498	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,567,171		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>LT Capital Lease</u>	(336)		43
44	<u>Unamortized Bond Fees</u>	(54,381)		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,512,454	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,552,952	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,046,219	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,599,172	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,854,960	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,854,960	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,191,259	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)	\$ 2,191,259	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)	\$ 4,046,219	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mercy Harvard Hospital Care

8049116

Report Period Beginning: 7/1/2016

Ending: 6/30/2017

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 61,411,159	1
2	Discounts and Allowances for all Levels	(36,688,013)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 24,723,146	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	93,916	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	3,011	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 96,927	23
D. Non-Operating Revenue			
24	Contributions	3,847	24
25	Interest and Other Investment Income***	1,491	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,338	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income & Misc		28
28a	Gain/Loss on Equip Disposal		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 24,825,411	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,709,410	31
32	Health Care	13,817,735	32
33	General Administration	5,109,998	33
B. Capital Expense			
34	Ownership	1,997,008	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)*	\$ 22,634,151	40
41	Income before Income Taxes (line 30 minus line 40)**	2,191,260	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,191,260	43

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

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

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

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

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

Facility Name & ID Number Mercy Harvard Hospital Care

8049116

Report Period Beginning:

7/1/2016

Ending:

6/30/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	3,760	4,574	\$ 334,212	\$ 73.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	77,935	88,469	3,938,521	44.52	3
4	Licensed Practical Nurses	5,368	6,063	105,599	17.42	4
5	CNAs & Orderlies	28,926	31,634	498,579	15.76	5
6	CNA Trainees					6
7	Licensed Therapist	9,581	10,696	431,821	40.37	7
8	Rehab/Therapy Aides	1,494	1,660	37,385	22.52	8
9	Activity Director	1,883	2,104	37,488	17.82	9
10	Activity Assistants	1,918	2,086	36,288	17.40	10
11	Social Service Workers	1,852	2,124	61,897	29.14	11
12	Dietician	2,201	2,473	74,079	29.96	12
13	Food Service Supervisor	2,706	2,928	63,821	21.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,755	23,116	274,499	11.87	15
16	Dishwashers					16
17	Maintenance Workers			193,192		17
18	Housekeepers	13,107	14,385		0.00	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator			173,373		21
22	Other Administrative	7,233	8,925		0.00	22
23	Office Manager					23
24	Clerical	11,964	13,879	247,585	17.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	208	208	40,348	193.98	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,219	5,817	160,295	27.56	31
32	Other Health Care(specify)	52,057	58,613	1,968,024	33.58	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	248,167	279,754	\$ 8,677,006 *	\$ 31.02	34

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

** See instructions.

B. CONSULTANT SERVICES

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

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	7,978	\$ 548,452	10-3	50
51	Licensed Practical Nurses	86	3,925	10-3	51
52	Certified Nurse Assistants/Aides	140	3,679	10-3	52
53	TOTAL (lines 50 - 52)	8,204	\$ 556,056		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Clerical Staff	Clerk	0	\$ 58,281	Workers' Compensation Insurance	\$ 77,453	IDPH License Fee	\$		
				Unemployment Compensation Insurance	12,309	Advertising: Employee Recruitment			
				FICA Taxes	687,476	Health Care Worker Background Check			
				Employee Health Insurance	1,054,730	(Indicate # of checks performed _____)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Professional Memberships & Dues	91,846		
				Life & Disability Insurance	33,614	Publications	889		
				Pension	285,961	Allocated to Non SNF areas	(44,149)		
				Employer TDA Match	89,864				
				Accrued Paid Leave	48,054				
				Employee Health & Other Benefits	163,145	Less: Public Relations Expense	()		
				Allocated to Ancillary Cost Centers (col 5)	(323,664)	Non-allowable advertising	()		
				Allocated to non SNF areas (col 7)	(1,701,353)	Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,281	TOTAL (agree to Schedule V, line 22, col.8)		\$ 427,589	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 48,586
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Hospital Tax Assessment			\$ 527,042			\$	Out-of-State Travel	\$	
Memberships & Dues			71,621						
Admin Salaries/ Interco Rent (Net)			(97,057)				In-State Travel	32,984	
Other Allocations			223,365						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 724,971				Seminar Expense		
							Allocated to Non SNF areas	(15,703)	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 15,807	TOTAL		\$	TOTAL	\$ 17,281	

* Attach copy of IMRF notifications

**See instructions.

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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ not available Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 71,372
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. \$ 94,362
- (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. \$ 0
- (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