FOR BHF USE

LL1

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

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0051201

Facility Name: Mercy Circle

Address: 3659 West 99th Street (Number) Chicago (City) 60655 (Zip Code)

County: Cook

Telephone Number: (773) 253-3814 Fax # (773) 779-6094

HFS ID Number:

Date of Initial License for Current Owners: 05/06/2014

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: :Pamela Latovick Telephone Number: (734) 343-6628
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 07/01/2017 to 06/30/2018 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) Frances Lachowicz

(Title) Executive Director

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	23	Skilled (SNF)	23	8,395	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	23	TOTALS	23	8,395	7

B. Census-For the entire report period.

	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	3,655	1,976	2,536	8,167	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,655	1,976	2,536	8,167	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.28%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
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 05/01/2014

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 23 and days of care provided 2,424

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	177,243	35,483	684,674	897,400		897,400	(688,505)	208,895			1
2	Food Purchase		211,275		211,275		211,275	(152,320)	58,955			2
3	Housekeeping	152,983	23,348	114	176,445		176,445	(130,082)	46,363			3
4	Laundry			45,686	45,686	(1,508)	44,178	(29,101)	15,077			4
5	Heat and Other Utilities			235,869	235,869		235,869	(188,419)	47,450			5
6	Maintenance	231,761	28,796	231,383	491,940	8,248	500,188	(403,542)	96,646			6
7	Other (specify):*											7
8	TOTAL General Services	561,987	298,902	1,197,726	2,058,615	6,740	2,065,355	(1,591,969)	473,386			8
	B. Health Care and Programs											
9	Medical Director			32,700	32,700		32,700	(2,790)	29,910			9
10	Nursing and Medical Records	1,532,513	64,838	6,505	1,603,856	31,243	1,635,099	(641,078)	994,021			10
10a	Therapy											10a
11	Activities	174,716	7,110	11,042	192,868	864	193,732	(127,614)	66,118			11
12	Social Services	86,398		912	87,310	752	88,062	(22,294)	65,768			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,793,627	71,948	51,159	1,916,734	32,859	1,949,593	(793,776)	1,155,817			16
	C. General Administration											
17	Administrative	51,691			51,691		51,691	(31,185)	20,506			17
18	Directors Fees											18
19	Professional Services			718,179	718,179	(59,453)	658,726	(397,403)	261,323			19
20	Dues, Fees, Subscriptions & Promotions			304,527	304,527	(44,087)	260,440	(201,246)	59,194			20
21	Clerical & General Office Expenses	284,359	23,105	59,387	366,851	171	367,022	(223,023)	143,999			21
22	Employee Benefits & Payroll Taxes			695,836	695,836		695,836	(233,294)	462,542			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,467	16,467	25,685	42,152	(25,787)	16,365			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			65,975	65,975		65,975	(39,802)	26,173			26
27	Other (specify):*			286,052	286,052		286,052	(286,052)				27
28	TOTAL General Administration	336,050	23,105	2,146,423	2,505,578	(77,684)	2,427,894	(1,437,792)	990,102			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,691,664	393,955	3,395,308	6,480,927	(38,085)	6,442,842	(3,823,537)	2,619,305			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 Circle #0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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			1,098,481	1,098,481		1,098,481	(879,247)	219,234			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,078,487	1,078,487		1,078,487	(893,575)	184,912			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			120,000	120,000		120,000	(120,000)				34
35	Rent-Equipment & Vehicles			16,357	16,357	(6,402)	9,955	(8,308)	1,647			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,313,325	2,313,325	(6,402)	2,306,923	(1,901,130)	405,793			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			663,120	663,120		663,120		663,120			39
40	Barber and Beauty Shops			37,273	37,273		37,273		37,273			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					44,487	44,487		44,487			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			700,393	700,393	44,487	744,880		744,880			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,691,664	393,955	6,409,026	9,494,645		9,494,645	(5,724,667)	3,769,978			45

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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(36,871)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(25,774)	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	(8)	20		18
19	Entertainment	(863)	24		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	(166,052)	27		24
25	Fund Raising, Advertising and Promotional	(108,860)	20		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)**	$ (338,428)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (338,428)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Mercy Circle

ID# 0051201

Report Period Beginning: 07/01/2017

Ending: 06/30/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Garage Parking Fees	$ (12,465)	6	1
2	Miscellaneous Revenue	(3,974)	21	2
3	Nursing Supplies/Briefs for AL/IL/Memory Care	(2,842)	10	3
4	Freight/Forms for AL/IL/Memory Care	(39)	21	4
5	Nursing Wages for AL/IL/Memory Care	(638,236)	10	5
6	Benefits for AL/IL/Memory Care	(47,690)	22	6
7	Physican Fees for AL/IL/Memory Care	(2,790)	9	7
8	Late Fee - Bed Tax	(928)	20	8
9	Late Fee - Lease Payment	(76)	35	9
10	Miscellaneous - Postage, Jury Duty, Telephone	(10)	21	10
11	Mscellaneous - Catering Income	(1,953)	1	11
12	Miscellaneous - Maintenance	(7,308)	6	12
13	Miscellaneous - Benefits	(1,812)	22	13
14	Penalty related to Survey	(1,430)	20	14
15	Fines and Penalties - in Travel	(37)	24	15
16	Unsupported Expense	(500)	35	16
17	Contributions	(120,000)	27	17
18	Remove Dietary Expense allocated to AL/IL	(649,681)	1	18
19	Remove Housekeeping Expense allocated to AL/IL	(130,082)	3	19
20	Remove Laundry Expense allocated to AL/IL	(29,101)	4	20
21	Remove Utilities allocated to AL/IL	(188,419)	5	21
22	Remove Maintenance Expense allocated to AL/IL	(383,769)	6	22
23	Remove Activity Expense allocated to AL/IL	(127,614)	11	23
24	Remove Social Service Expense allocated to AL/IL	(22,294)	12	24
25	Remove Admin Expense allocated to AL/IL	(31,185)	17	25
26	Remove Professional Services allocated to AL/IL	(397,403)	19	26
27	Remove Miscellaneous Expense allocated to AL/IL	(90,020)	20	27
28	Remove Gen Office Expenses allocated to AL/IL	(219,000)	21	28
29	Remove Travel/Seminar Expense allocated to AL/IL	(24,887)	24	29
30	Remove Insurance Expsnse allocated to AL/IL	(39,802)	26	30
31	Remove Depreciation Expense allocated to AL/IL	(879,247)	30	31
32	Remove Interest Expense allocated to AL/IL	(867,801)	32	32
33	Remove Rental Expense allocated to AL/IL	(7,732)	35	33
34	Remove Benefits allocated to AL/IL	(183,792)	22	34
35	Remove Food allocated to AL/IL	(152,320)	2	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**	(5,266,239)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	(688,505)	0	0	0	0	0	0	0	0	0	0	(688,505)	1
2	Food Purchase	(152,320)	0	0	0	0	0	0	0	0	0	0	(152,320)	2
3	Housekeeping	(130,082)	0	0	0	0	0	0	0	0	0	0	(130,082)	3
4	Laundry	(29,101)	0	0	0	0	0	0	0	0	0	0	(29,101)	4
5	Heat and Other Utilities	(188,419)	0	0	0	0	0	0	0	0	0	0	(188,419)	5
6	Maintenance	(403,542)	0	0	0	0	0	0	0	0	0	0	(403,542)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,591,969)	0	0	0	0	0	0	0	0	0	0	(1,591,969)	8
	B. Health Care and Programs													
9	Medical Director	(2,790)	0	0	0	0	0	0	0	0	0	0	(2,790)	9
10	Nursing and Medical Records	(641,078)	0	0	0	0	0	0	0	0	0	0	(641,078)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(127,614)	0	0	0	0	0	0	0	0	0	0	(127,614)	11
12	Social Services	(22,294)	0	0	0	0	0	0	0	0	0	0	(22,294)	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	(793,776)	0	0	0	0	0	0	0	0	0	0	(793,776)	16
	C. General Administration													
17	Administrative	(31,185)	0	0	0	0	0	0	0	0	0	0	(31,185)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(397,403)	0	0	0	0	0	0	0	0	0	0	(397,403)	19
20	Fees, Subscriptions & Promotions	(201,246)	0	0	0	0	0	0	0	0	0	0	(201,246)	20
21	Clerical & General Office Expenses	(223,023)	0	0	0	0	0	0	0	0	0	0	(223,023)	21
22	Employee Benefits & Payroll Taxes	(233,294)	0	0	0	0	0	0	0	0	0	0	(233,294)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(25,787)	0	0	0	0	0	0	0	0	0	0	(25,787)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(39,802)	0	0	0	0	0	0	0	0	0	0	(39,802)	26
27	Other (specify):*	(286,052)	0	0	0	0	0	0	0	0	0	0	(286,052)	27
28	TOTAL General Administration	(1,437,792)	0	0	0	0	0	0	0	0	0	0	(1,437,792)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,823,537)	0	0	0	0	0	0	0	0	0	0	(3,823,537)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mercy Circle # 0051201 **Report Period Beginning:** 07/01/2017 **Ending:** 06/30/2018

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	(879,247)	0	0	0	0	0	0	0	0	0	0	(879,247)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(893,575)	0	0	0	0	0	0	0	0	0	0	(893,575)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(120,000)	0	0	0	0	0	0	0	0	0	(120,000)	34
35	Rent-Equipment & Vehicles	(8,308)	0	0	0	0	0	0	0	0	0	0	(8,308)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,781,130)	(120,000)	0	0	0	0	0	0	0	0	0	(1,901,130)	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)**	(5,604,667)	(120,000)	0	0	0	0	0	0	0	0	0	(5,724,667)	45

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sisters of Mercy of the Americss	100%	Catherine's Place	Farmington Hills, MI			
West Midwest Community, Inc.						
Laura Reicks, RSM	BOD					
Michael Davis	BOD					
John Eber	BOD					
Margaret Mary Hinz, RSM	BOD					
Judith Miemet, RSM	BOD					

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Land Lease	$ 120,000	Sisters of Mercy of the Americas West Midwest Comm., Inc.	100.00%	$	$ (120,000)	1
2	V	19	Leadership wages/benefits	38,173	Sisters of Mercy of the Americas West Midwest Comm., Inc.	100.00%	38,173		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			$ 158,173			$ 38,173	$ * (120,000)	14

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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	Charles Stevenson	BOD						1
2	Kevin Connelly	BOD						2
3	Margaret Johnson, RSM	BOD						3
4	Frances Lachowicz	BOD						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 Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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									$		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 Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 6/30/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First National Bank		X	Construction of Facility			$ 26,250,000	$ 18,277,659		0.0340	$ 917,678	1
2	West Midwest FIDES	X					15,814,000	13,339,782		0.0325	130,930	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 42,064,000	$ 31,617,441			$ 1,048,608	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 42,064,000	$ 31,617,441			$ 1,048,608	15

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

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

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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mercy Circle COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051201

CONTACT PERSON REGARDING THIS REPORT Pamela Latovick

TELEPHONE (734) 343-6628 FAX #: (734) 343-6461

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,236 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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).

Mercy Circle, Assisted Living/Memory Care, 53,692 sq. ft., 34 AL/9 MC Units
Mercy Circle, Independent Living, 66,078 sq. ft., 44 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	23			2014	$ 6,537,662	$ 163,442	40	$ 163,442	$	$ 762,727	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Aluminum Logo Sign			2015	631	63	10	63		247	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
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,538,293	$ 163,505		$ 163,505	$	$ 762,974	70

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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	$ 368,169	$ 41,781	$ 41,781	$	5/7/10	$ 182,894	71
72	Current Year Purchases	12,535	1,093	1,093		5/10	1,093	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 380,704	$ 42,874	$ 42,874	$		$ 183,987	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	14 Passenger Van-Res Transp	Passenger Bus, 2013	2014	$ 55,317	$ 4,610	$ 4,610	$	4	$ 55,317	76
77	Utility Truck-Maintenance	Dodge Ram Truck, 2013	2014	26,033	2,169	2,169		4	26,033	77
78	Car - Resident Transport	Toyota Camry, 2010	2014	14,344	3,287	3,287		4	14,344	78
79	Car - Resident Transport	Toyota Avalon, 2007	2014	12,171	2,789	2,789		4	12,171	79
80	TOTALS			$ 107,865	$ 12,855	$ 12,855	$		$ 107,865	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,026,862	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 219,234	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 219,234	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,054,826	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building, 2014	$ 32,307,965	$ 807,699	$ 3,769,262	86
87	Aluminum Logo Sign, 2015	3,119	312	1,222	87
88	Equipment, Prior Years	629,130	69,690	321,393	88
89	Equipment, Current Year	37,106	1,546	1,546	89
90					90
91	TOTALS	$ 32,977,320	$ 879,247	$ 4,093,423	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 9,380 Description: Copier, Equipment, Postage Meter
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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.

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	39-3	hrs	$		$ 238,022	$		$ 238,022	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			41,650	981		42,631	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			285,664	1,844		287,508	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts			72,322			72,322	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Med Spl/Beds/Oxygen	39-3				9,346			9,346	12
13	Other (specify): Lab/X-ray	39-3				13,291			13,291	13
14	TOTAL			$		$ 660,295	$ 2,825		$ 663,120	14

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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2018 (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	$ 1,812,127	$	1
2	Cash-Patient Deposits	11,299		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 176,375)	280,015		3
4	Supply Inventory (priced at)	24,196		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,229		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,130,866	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	38,849,377		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,154,804		16
17	Accumulated Depreciation (book methods)	(5,148,249)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,176,369		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(258,770)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: Land Lease)	1,791,458		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 38,564,989	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 40,695,855	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,273,609	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	151,852		28
29	Short-Term Notes Payable	456,142		29
30	Accrued Salaries Payable	206,110		30
31	Accrued Taxes Payable (excluding real estate taxes)	207		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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,087,920	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	13,339,782		40
41	Bonds Payable	18,277,659		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Restricted Assets/Donations	3,518,366		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 35,135,807	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 41,223,727	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (527,872)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 40,695,855	$	48

***(See instructions.)**

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,147,081	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,147,081	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(527,872)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Change in unrestricted net assets**	(4,147,081)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (4,674,953)	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)**	$ (527,872)	24 *

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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	$ 7,276,627	1
2	Discounts and Allowances for all Levels	54,235	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,330,862	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	332,048	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 332,048	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	37,765	13
14	Non-Patient Meals	36,871	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	12,465	16
17	Sale of Drugs	94,646	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,470	19
20	Radiology and X-Ray	10,338	20
21	Other Medical Services	107,303	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 310,858	23
	D. Non-Operating Revenue		
24	Contributions	967,231	24
25	Interest and Other Investment Income***	25,774	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 993,005	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,966,773	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,059,047	31
32	Health Care	1,874,838	32
33	General Administration	2,543,663	33
	B. Capital Expense		
34	Ownership	2,316,673	34
	C. Ancillary Expense		
35	Special Cost Centers	700,424	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)***	$ 9,494,645	40
41	**Income before Income Taxes (line 30 minus line 40)****	(527,872)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (527,872)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 664,565	44
45	Private Pay - Net Inpatient Revenue	500,534	45
46	Medicare - Net Inpatient Revenue	1,404,390	46
47	Other-(specify) **Insurance**	29,300	47
48	Other-(specify) **Assisted/Independent Living**	4,732,073	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,330,862	49

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

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

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

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

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	1,820	2,121	$ 99,339	$ 46.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,066	10,862	308,587	28.41	3
4	Licensed Practical Nurses	9,094	10,770	267,088	24.80	4
5	CNAs & Orderlies	49,949	55,378	827,168	14.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,708	1,999	67,797	33.92	9
10	Activity Assistants	6,323	6,989	106,919	15.30	10
11	Social Service Workers	2,809	3,133	86,398	27.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,227	2,328	38,166	16.39	14
15	Cook Helpers/Assistants	11,000	11,403	139,077	12.20	15
16	Dishwashers					16
17	Maintenance Workers	9,693	10,449	231,761	22.18	17
18	Housekeepers	8,531	9,687	152,983	15.79	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,979	3,424	110,512	32.28	22
23	Office Manager	1,727	2,080	61,229	29.44	23
24	Clerical	7,953	8,459	164,309	19.42	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	1,794	1,958	30,331	15.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,673	141,040	$ 2,691,664 *	$ 19.08	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	2,279	11/3	44
45	Social Service Consultant	43	2,736	12/3	45
46	Other(specify) Security	4,210	69,944	19/3	46
47	MDS Coordinator	154	13,773	10/5	47
48	Interim DON	195	17,471	10/5	48
49	TOTAL (lines 35 - 48)	4,638	$ 106,203		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Mercy Circle # 0051201 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Tirpak	HR Manager	0	$ 51,691
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 51,691

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Point Click Care	billing software	$ 20,841
Trinity Senior Living Communities	mgt fees/travel exp/consult	300,000
Corporation Service Company	lgl svcs - statuatory repres.	110
Plante & Moran, PLLC	financial statement review	28,500
Trinity Senior Living Communities	Adm salary/benefits	159,923
Sisters of Mercy - Americas	Email/Microsoft Office	5,120
Sisters of Mercy - Americas	Leadership wages/benefits	38,173
Access Media 3	Direct TV	49,849
Pointright	Clinical Software	4,275
Shred It	Shredding	2,221
Leaderstat	Recruiting for MDS position	15,673
Misc. Other Expense	See attcahed	93,494
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 718,179

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,792
Unemployment Compensation Insurance	39,057
FICA Taxes	193,965
Employee Health Insurance	353,863
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	17,530
403B Employer Match	48,641
Employee Appreciation	11,176
Expense allocated to AL/IL	(231,482)
TOTAL (agree to Schedule V, line 22, col.8)	$ 462,542

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	55,356
Health Care Worker Background Check	600
(Indicate # of checks performed 28)	
Patient Background Checks	
Dues & Subscriptions	11,092
Licenses & Taxes	12,361
Bank/Trust Acct/Letter of Credit fees	69,805
Dues/Fees allocated to AL/IL	(90,020)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 59,194

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Trinity Senior Living Comm. Travel	16,129
First Nat'l Bank - Travel to NE/MI	1,840
In-State Travel	
Miscellaneous Travel	527
Interim Consultants travel	9,916
Travel/Seminar Expense allocated to AL/IL	(24,887)
Seminar Expense	
Admin - Conferences	1,999
First Nat'l Bank - Seminar Expense	11,704
Entertainment Expense	(863)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,365

* 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? **Yes**
If YES, give association name and amount. **Leading Age Illinois - $6,459**

(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? **5 - 10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,882** Line **10-2**

(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. $ **44,487**
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? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **36,871**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
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? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

(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

Mercy Circle
Additional Support
FYE 6-30-18

Professional Services

Trinity Sr. Living Communities	300,000	Management Fee
MDI Achieve	7,282	Clinical Software
Pointclick Care Tech.	20,841	PCC - Billing/Clinical Software
Plante and Moran	28,500	Accounting Services, review of Financial Statements
Polsinelli, PC	1,100	Legal Counsel, theft, survey
NACC	475	Want ads
Pathway Health	48,076	Interim MDS/DON r/c $31,243 to line 10, $9,916 to line24
Jackson Lewis, PC	1,247	Legal services, empl/resident matters
Socialwork Consult. Group	2,016	$1,152 SW, r/c to line 12. $864 Act, r/c to line 11
Trinity Sr. Living Comunities	159,923	Administrator salary and benefits
NRC	1,069	Resident Satisfaction Survey
TSLC - expenses	16,129	Travel
TSLC - expenses	4,275	Pointright - Clinical Software
TSLC - expenses	282	Press Ganey
TSLC - expenses	156	Printing
Proven Business Systems	3,987	Copier Repair, r/c 53 to line 35
Access Media 3, Inc.	49,849	HD Direct TV Programming
Advanced Telecom	1,324	Cable for Copier
Sisters of Mercy Americas	38,173	Allocation from Sisters of Mercy
Sisters of Mercy Americas	4,120	Email/Office
Sisters of Mercy Americas	1,000	Development Fee
Careworx Corporation	96	Maintenance on Clinical Kiosks, reclass to line 6
Monica Gavino	500	Communication
Leaderstat	15,673	Recruiting for MDS Coordinator
Shred-It USA LLC	2,221	Shredding Services
Accruals	9,756	
Corporation Service Comp.	110	Statuatory Representation
Total	718,179	

Dues, Fees & Subscriptions

				Est # Checks	
Background Checks					
IL State Police	200		1/24/2018		
IL State Police	-	400	12/20/2017	28	Reclass from Social Services Line 12
	200	400	600	28	
Sales & Marketing	108,860	-108860	0		Remove as nonallowable
Adv./Empl Recruit	55,356		55,356		
Dues & Subscriptions	11,092		11,092		
IDPH License Fee			-		
Licenses & Fees	59,206	-46845	12,361		
Bank/Trust Act/LOC	69,805		69,805		
Fines & Penalties	8	-8	(0)		Remove as nonallowable
	304,527	(155,313)	149,214		
Allocated to AL/IL			(90,020)		
Net			59,194		

Leased Equipment

Cannon Finan Svcs	4,542	Graphic Equipment
	76	Late charges to be removed.
Martin Whalen Office Sol.	561	Copier Including $53 from Prof Svcs
Pitney Bowes Global	1,404	Postage Meter
PB Purchase Power	171	Stamps, reclass to line 21
Proven Business Solutions	6,284	Maintenance of Copiers, reclass to line 6
Everbank Commercial Finance	2,872	Equipment
Accrual	500	Remove, unsupported
Total	16,410	
Adjusted Leased Equip., L. 35	9,380	

Employee Benefits Line 22	Col. 3	Col. 7	Adjusted
Workers Compensation	24,231		24,231
Unemployment Comp.	21,493		21,493
FICA Taxes	172,332	(45,492)	126,840
Employee Health Insurance	380,195	(2,198)	377,997
Employee Life Insurance	20,437		20,437
Employee Pension			-
403B Employer Match	49,558		49,558
Employee Appreciation	8,000	-	8,000
	676,246	(47,690)	628,556

Col 7 adjustment reflects removal of direct AL/IL expense.

Travel

First Nat'l Bank Omaha	1,840	Admin	Travel/Lodging Omaha, NE/MI	
First Nat'l Bank Omaha	99	Admin	Reimb for local travel	
Payroll	122	Admin	Reimb for local travel	
Payroll	84	Maintenance	Reimb for local travel	
Payroll	221	N Admin	Reimb for local travel	
Pathway Health	9,916	Admin	Travel for temp DON, MDS Coord.	
TSLC - out of State	16,129	Admin	Travel of TSLC employees to Mercy Circle	
Total Travel	28,412			

Training/Seminars

Stockler, Joyce	575	Admin	Seminar	
First Nat'l Bank Omaha	37	Admin	Eden Event - Late fee	Adj off
First Nat'l Bank Omaha	500	Admin	Continuing Ed - IL	
First Nat'l Bank Omaha	620	Admin	LSNI	
First Nat'l Bank Omaha	5,197	Admin	Leading Age Training/Conference	
First Nat'l Bank Omaha	870	Admin	Bridgecare Consulting	
First Nat'l Bank Omaha	360	Admin	Education/Webinars	
First Nat'l Bank Omaha	657	Admin	HIN (Health Info Network) Training	
First Nat'l Bank Omaha	2,898	Admin	NIU Outreach	
Mercy Network on Aging	395	Admin	Seminar	
First Nat'l Bank Omaha	-	Admin	HIN (Health Info Network) 2 seminars online	
Payroll	863	Admin	Meetings/Seminars	Marketing, Adj off
Payroll/Petty Cash	9	Nursing Adm	Meetings/Seminars	
First Nat'l Bank Omaha	360	Maintenance	Supplies	reclass to line 6
First Nat'l Bank Omaha	602	Maintenance	Seminars	
Other Training	157	Admin		
	14,100			
Travel +Training - !st NB Maint	42,152	agrees Pg 3, line 24 column 6		

Mercy Circle
Consultants
FYE 6-30-18

Activities					Act		SS	
10/31/2017	Socialwork Consultation Group	10.8	688.00		7	416	4	272
11/30/2017	Socialwork Consultation Group	9.5	598.50		10	599		
12/31/2017		6.0	384.00				6	384
1/31/2018		9.0	576.00		4	256	5	320
2/28/2018		11.5	736.00		7	448	5	288
4/19/2018		4.0	256.00		4	256		
4/30/2018		8.8	560.00		5	304	4	256
5/31/2018		4.0	256.00		-	-	4	256
		63.5	4,054.50		36	2,279	28	1,776
Admin								
9/30/2017	Socialwork Consultation Group	7.0	448.00	SS	-	-	7	448
	r/c'd to Social Services							
Social Services								
8/31/2017	Socialwork Consultation Group	8.0	512.00		-	-	8	512
	Grand Total	**78.5**	**5,014.5**		**36**	**2,279**	**43**	**2,736**

Maintenance

Date		Hours	$	
6/20/2017	Excel Security Services, Inc.	84	1,354.08	
6/27/2017		84	1,354.08	
7/3/2017		84	1,354.08	
7/10/2017		84	1,547.52	
7/17/2017		88	1,418.56	
8/9/2017		84	1,354.08	
7/31/2017		84	1,354.08	
8/7/2017		84	1,354.08	
8/14/2017		84	1,354.08	
8/21/2017		88	1,418.56	
8/28/2017		84	1,354.08	
9/4/2017		84	1,418.56	
9/11/2017		84	1,354.08	
9/18/2017		84	1,354.08	
10/16/2017		84	1,354.08	
9/25/2017		84	1,354.08	
10/2/2017		86	1,402.44	
10/9/2017		84	1,354.08	
10/23/2017		84	1,354.08	
10/30/2017		84	1,354.08	
11/6/2017		84	1,354.08	
11/13/2017		84	1,450.80	
11/20/2017		84	1,354.08	
11/27/2017		84	1,547.52	
12/4/2017		84	1,354.08	
12/11/2017		84	1,354.08	
12/18/2017		84	1,354.08	
12/26/2017		84	1,418.56	
1/2/2018		84	1,450.80	
1/8/2018		84	1,386.32	
1/15/2018		84	1,474.88	
1/22/2018		84	1,437.52	
1/29/2018		84	1,407.84	
2/12/2018		84	1,407.84	
2/5/2018		84	1,407.84	
2/19/2018		84	1,407.84	
2/26/2018		84	1,407.84	
3/5/2018		84	1,407.84	
3/12/2018		84	1,407.84	
2/26/2018		84	1,407.84	
4/2/2018		84	1,508.40	incl in Linens, r/c to line 6
4/9/2018		83	1,391.08	
4/16/2018		84	1,407.84	
4/23/2018		84	1,407.84	
5/7/2018		84	1,407.84	
4/30/2018		84	1,407.84	
5/21/2018		84	1,407.84	
5/29/2018		84	1,474.88	
6/4/2018		84	1,407.84	
6/11/2018		85	1,405.84	
		4,210	69,943.60	

Pathway Health					MDS		DON	
7/22/2017	Pathway Health	23	2,047.00		23	2,047		
7/29/2017		25	2,225.00		25	2,225		
8/5/2017		33.75	3003.75		33	3,004		
8/12/2017		31	2759		31	2,759		
8/19/2017		27	2403		27	2,403		
8/26/2017		15	1335		15	1,335		
8/26/2017		40	3600				40	3,600
8/31/2017		40	3600				40	3,600
9/9/2017		40	3600				40	3,600
9/16/2017		40	3600				40	3,600
8/31/2017		16.75	1490.75				17	1,491
9/9/2017		17.75	1579.75		-	-	18	1,580
		349.25	31243.25		154	13,773	195	17,471

Mercy Circle
Adjustments to Expense
FYE 6-30-18

Direct Expense for AL/IL and MC

Description	Amount	Line #
Supplies/Briefs	(2,842)	10
Forms/Misc	(39)	21
Nursing Wages	(638,236)	10
Benefits	(47,690)	22
Physician Fees	(2,790)	9
Total	(691,597)	

Line #	1		3	4	5	6	11	12	17	19	20	21	24	26	30	32	35	
Cost Center	Dietary	Food	Housekpg	Laundry	Utilities	Maintenance	Activities	Soc. Svcs.	Admin	Prof Svcs	Misc.	Gen Office	Trav/Sem	Insurance	Depreciation	Interest	Rent Equip	Total
Direct Expense	858,576	211,275	176,445	44,178	235,869	480,415	193,732	88,062	51,691	658,726	149,214	363,009	41,252	65,975	1,098,481	1,052,713	9,379	5,778,992
Benefits	42,560	-	36,735	-	-	55,651	41,954	20,746	12,412	-	-	68,282	-	-	-	-	-	278,340
Total Expense to Allocate	901,136	211,275	213,180	44,178	235,869	536,066	235,686	108,808	64,103	658,726	149,214	431,291	41,252	65,975	1,098,481	1,052,713	9,379	6,057,332
Direct Expense																		
AL	485,329	113,787	57,695	29,101	59,049	120,269	127,614	21,179	22,204	282,951	64,094	155,928	17,720	28,339	-	-	-	1,585,258
IL	164,352	38,533	72,387	-	129,370	263,500	-	1,115	8,981	114,452	25,926	63,072	7,167	11,463	879,247	867,801	7,732	2,655,098
SNF	251,455	58,955	46,363	15,077	47,450	96,646	66,118	65,768	20,506	261,323	59,195	144,009	16,365	26,173	219,234	184,912	1,647	1,581,196
Total	901,136	211,275	176,445	44,178	235,869	480,415	193,732	88,062	51,691	658,726	149,214	363,009	41,252	65,975	1,098,481	1,052,713	9,379	5,821,552
Benefits																		
AL	22,922		12,012			13,932	27,635	4,990	5,332			29,330						116,152
IL	7,762		15,071			30,524	-	263	2,157			11,864						67,640
SNF	11,876		9,652			11,196	14,318	15,494	4,924			27,088						94,548
Total	42,560		36,735			55,651	41,954	20,746	12,412			68,282						278,340
Statistic	Meals		Adj Sq Ftge	Patient Days	Sq Footage	Sq Footage	Patient Days	Discharges	Accum Cost	Accum Cost	Accum Cost	Accum Cost	Accum Cost	Accum Cost	Depr Exp	Bldg Cost	Bldg Cost	
AL	47,289	47,289	30,160	15,763	30,160	30,160	15,763	19	1,787,111	1,787,111	1,787,111	1,787,111	1,787,111	1,787,111				
IL	16,014	16,014	37,840	-	66,078	66,078	-	1	722,877	722,877	722,877	722,877	722,877	722,877	879,247	32,977,319	32,977,319	
SNF	24,501	24,501	24,236	8,167	24,236	24,236	8,167	59	1,650,507	1,650,507	1,650,507	1,650,507	1,650,507	1,650,507	219,234	7,026,863	7,026,863	
Total	87,804	87,804	92,236	23,930	120,474	120,474	23,930	79	4,160,495	4,160,495	4,160,495	4,160,495	4,160,495	4,160,495	1,098,481	40,004,182	40,004,182	

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

																		Nursing	Grand Total	Ben Check
Wages	177,243	152,983			231,761	174,716	86,398	51,691				284,359					1,159,151	1,532,513	2,691,664	
Benefits	42,560.36	36,734.94	-	-	55,651	41,954	20,746	12,412	-	-	68,282	-	-	-	-	-	278,340	367,994	646,334	-

Mercy Circle
Adjustments to Expense
FYE 6-30-18

Description	Amount	Line #	
Meal Income	(36,871)	1	
Garage/Parking Fees	(12,465)	6	
Miscellaneous Revenue	(3,974)	21	Administrative/LTC only
Postage/Jury Duty/Tel	(10)	21	
Catering Income	(1,953)	1	Revenue Offsets
Maintenance Misc Rev	(7,308)	6	
Benefits	(1,812)	22	
Interest Income	(25,774)	32	
Bad Debt Expense	(166,052)	27	
Survey Penalty	(1,430)	20	
Marketing Expense	(108,860)	20	
	(863)	24	
Fines & Penalties	(8)	20	F/S Expense Offsets
Fines & Penalties - in Travel	(37)	24	
Unsupported Expense	(500)	35	
Late Fee - Bed Tax	(928)	20	
Late Fee - Lease Payment	(76)	35	
Contributions	(120,000)	27	
Provider Participation Fee	44,487	42	
	(44,487)	20	
Background Checks Fee	400	20	
	(400)	12	
Social Services	1,152	12	
Activities	864	11	
	(2,016)	19	
Maintenance Expense	96	6	
	(149)	19	
Copier	53	35	
General Supplies	171	21	
	(171)	35	Reclasses of expense
Interim MDS/DON	31,243	10	
Travel Expense	9,916	24	
	(41,159)	19	
TSLC Travel	16,129	24	
	(16,129)	19	
Manintenance Supplies	360	6	
	(360)	24	
Security Expense	1,508	6	
	(1,508)	4	
Maintenance Repair	6,284	6	
	(6,284)	35	