		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0032680

Facility Name: Mercy Rehab and Care Center

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

County: St Clair

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/19 to 06/30/20 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) Gail Kimmle
(Title) Administrator

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

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	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	18,458	8,889	5,909	33,256	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,458	8,889	5,909	33,256	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.93%

D. How many bed reserve days during this year were paid by the Department?
None (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 10/08/1987

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 3,828

Medicare Intermediary Novitas Solutions, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 06/30/20

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	275,546	30,317	9,355	315,218		315,218		315,218			1
2	Food Purchase		273,916		273,916		273,916	(749)	273,167			2
3	Housekeeping	202,650	44,417		247,067		247,067		247,067			3
4	Laundry	55,999	23,328		79,327		79,327		79,327			4
5	Heat and Other Utilities			138,656	138,656		138,656		138,656			5
6	Maintenance	102,656	9,983	103,583	216,222		216,222	11,271	227,493			6
7	Other (specify):* Waste Disposal			35,135	35,135		35,135		35,135			7
8	TOTAL General Services	636,851	381,961	286,729	1,305,541		1,305,541	10,522	1,316,063			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,729,942	324,645	93,936	3,148,523		3,148,523		3,148,523			10
10a	Therapy	107,336	50		107,386		107,386		107,386			10a
11	Activities	62,949	7,053	2,688	72,690		72,690		72,690			11
12	Social Services	76,393		2,688	79,081		79,081		79,081			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,976,620	331,748	113,712	3,422,080		3,422,080		3,422,080			16
	C. General Administration											
17	Administrative	116,723			116,723		116,723		116,723			17
18	Directors Fees											18
19	Professional Services			8,100	8,100		8,100		8,100			19
20	Dues, Fees, Subscriptions & Promotions			39,698	39,698	(255)	39,443	(7,096)	32,347			20
21	Clerical & General Office Expenses	219,324	28,568	111,912	359,804		359,804		359,804			21
22	Employee Benefits & Payroll Taxes			604,938	604,938		604,938		604,938			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,898	4,898	255	5,153		5,153			24
25	Other Admin. Staff Transportation			1,644	1,644		1,644		1,644			25
26	Insurance-Prop.Liab.Malpractice			102,042	102,042		102,042	25,390	127,432			26
27	Other (specify):*											27
28	TOTAL General Administration	336,047	28,568	873,232	1,237,847		1,237,847	18,294	1,256,141			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,949,518	742,277	1,273,673	5,965,468		5,965,468	28,816	5,994,284			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 Rehab and Care Center #0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			25,321	25,321		25,321	283,640	308,961			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,638	19,638		19,638	405,860	425,498			32
33	Real Estate Taxes							79,156	79,156			33
34	Rent-Facility & Grounds			558,000	558,000		558,000	(558,000)				34
35	Rent-Equipment & Vehicles			39,653	39,653		39,653		39,653			35
36	Other (specify):*											36
37	TOTAL Ownership			642,612	642,612		642,612	210,656	853,268			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		170,294	671,601	841,895		841,895		841,895			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			258,240	258,240		258,240		258,240			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		170,294	929,841	1,100,135		1,100,135		1,100,135			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,949,518	912,571	2,846,126	7,708,215		7,708,215	239,472	7,947,687			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 Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(749)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(19,638)	32		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	(2,196)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(264)	20		28
29	Other-Attach Schedule	(4,636)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (27,483)		$	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)	266,955	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 266,955		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 239,472		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Mercy Rehab and Care Center

ID# 0032680

Report Period Beginning: 07/01/19

Ending: 06/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Lobbying & PAC Dues	$ (2,646)	20	1
2	Eliminate 2021 IDPH license fee	(1,990)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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**	(4,636)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(749)	0	0	0	0	0	0	0	0	0	0	(749)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	11,271	0	0	0	0	0	0	0	0	0	11,271	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(749)	11,271	0	0	0	0	0	0	0	0	0	10,522	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,096)	0	0	0	0	0	0	0	0	0	0	(7,096)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	25,390	0	0	0	0	0	0	0	0	0	25,390	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(7,096)	25,390	0	0	0	0	0	0	0	0	0	18,294	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,845)	36,661	0	0	0	0	0	0	0	0	0	28,816	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 **Report Period Beginning:** 07/01/19 **Ending:** 06/30/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	283,640	0	0	0	0	0	0	0	0	0	283,640	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,638)	425,498	0	0	0	0	0	0	0	0	0	405,860	32
33	Real Estate Taxes	0	79,156	0	0	0	0	0	0	0	0	0	79,156	33
34	Rent-Facility & Grounds	0	(558,000)	0	0	0	0	0	0	0	0	0	(558,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(19,638)	230,294	0	0	0	0	0	0	0	0	0	210,656	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)**	(27,483)	266,955	0	0	0	0	0	0	0	0	0	239,472	45

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rosewood Care Center Holding Co.	100	N/A		SILDA LLC	St. Louis MO	Real Estate Lsg.

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 558,000	SILDA LLC		$	$ (558,000)	1
2	V	6	Maintenance		SILDA LLC		11,271	11,271	2
3	V	26	Property Insurance		SILDA LLC		25,390	25,390	3
4	V	30	Depreciation		SILDA LLC		283,640	283,640	4
5	V	32	Interest		SILDA LLC		425,498	425,498	5
6	V	33	Real Estate Taxes		SILDA LLC		79,156	79,156	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 558,000			$ 824,955	$ * 266,955	14

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

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 Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	St. Louis Bank		X	Mortgage	$65,394.00	8/28/15	$ 13,600,000	$ 8,234,711	8/28/20	5.5000	$ 425,498	1
2												2
3												3
4												4
5												5
	Working Capital											
6		X		Miscellaneous							19,638	6
7												7
8												8
9	TOTAL Facility Related				$65,394.00		$ 13,600,000	$ 8,234,711			$ 445,136	9
	B. Non-Facility Related*											
10				Related Party Interest							(19,638)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (19,638)	14
15	TOTALS (line 9+line14)						$ 13,600,000	$ 8,234,711			$ 425,498	15

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

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

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 76,000	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.)		$ 76,156	2
3. Under or (over) accrual (line 2 minus line 1).		$ 156	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 79,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 79,156	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	69,254	8
	2016	72,775	9
	2017	73,835	10
	2018	75,200	11
	2019	77,111	12

Line 2: 2nd installment of 2018 taxes $37,599.89 and 1st installment of 2019 taxes $38,555.72 = $76,155.61

Line 4: 1/2 of the 2019 taxes due plus 1/2 of the estimated 2020 taxes due.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mercy Rehab and Care Center COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0032680

CONTACT PERSON REGARDING THIS REPORT Cindy Teftteller

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

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-09.0-402-023	Wandering Woods	$ 77,111.44	$ 77,111.44
2.		Lot/SEC-3 A02410700	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,111.44	$ 77,111.44

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization:
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	Nursing Home		1987	$ 126,031	1
2					2
3	TOTALS			$ 126,031	3

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	102			1987	$ 2,175,969	$	20-25	$	$	$ 2,175,969	4
5				1988	253,539		25			253,539	5
6				1990	222,972					222,972	6
7				1991	6,679		25			6,679	7
8											8
	Improvement Type**										
9	Walk in Cooler			1987	5,515		10			5,515	9
10	Exhaust Hood			1987	6,498		10			6,498	10
11	Paging Systems			1987	632		10			632	11
12	Carpet			1987	39,910		10			39,910	12
13	Hospital Track/Curtains			1987	8,075		10			8,075	13
14	Signs			1987	2,916		10			2,916	14
15	Telephone Equipment			1987	3,180		10			3,180	15
16	Outside Sign			1987	4,504		10			4,504	16
17	Water Heater			1987	3,650		10			3,650	17
18	Walk in Freezer			1988	3,936		15			3,936	18
19	Nurse Call System			1988	670		15			670	19
20	Signs			1989	2,000		10			2,000	20
21	Exhaust Fan			1989	530		10			530	21
22	Water Treatment System			1989	5,905		10			5,905	22
23	Door Gaurds			1989	5,509		10			5,509	23
24	Corner Gaurds			1990	1,446		10			1,446	24
25	Carpeting			1990	2,215		10			2,215	25
26	Hot Water Storage			1996	2,607		10			2,607	26
27	Landscaping/Fencing			1987	25,279		25			25,279	27
28	Water Hydrant			1988	1,677		10			1,677	28
29	Trees and Seeding			1988	745		10			745	29
30	Seeding			1988	4,290		10			4,290	30
31	Parking Lot Expansion			1988	621		25			621	31
32	Road			1990	431,970		25			431,970	32
33	Parking Lot Expansion			1989	27,592		15			27,592	33
34	Landscaping/Fencing			1989	1,904		25			1,904	34
35	Lawn Sprinkler System			1992	10,926		25			10,926	35
36	Backflow for Sprinkler			1993	2,909		25			2,909	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 Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sinks	1987	$ 4,156	$	10	$	$	$ 4,156	37
38	Hank Sinks	1987	181		10			181	38
39	Heat Pumps	2003	3,746		10			3,746	39
40	Roof Work	2004	21,620		40	541	541	8,650	40
41	Storage Building	2004	13,980		25	559	559	8,760	41
42	Parking Lot Seal & Stripe	2004	3,993		2			3,993	42
43	Telephone Power Pole	2005	10,875		10			10,875	43
44	Fire Alarm System	2005	9,668		10			9,668	44
45	Satellite System	2006	9,002		10			9,002	45
46	Heat Pumps	2007	37,285		10			37,285	46
47	Evaporating Cooling Table	2007	48,252		10			48,252	47
48	Water Heater	2007	3,545		10			3,545	48
49	Compressor Blower Motor	2007	2,938		10			2,938	49
50	Water Heater	2007	3,595		10			3,595	50
51	Electrical Wiring	2009	3,153		10			3,153	51
52	Painting Exterior Building	2010	8,792		40	220	220	2,218	52
53	Heat Pumps	2009	6,327		10	210	210	6,327	53
54	Exterior Doors	2009	9,014		10	301	301	9,014	54
55	Wall Cabinets	2009	1,009		10	33	33	1,009	55
56	Sprinkler Pipe	2010	14,909		10	1,118	1,118	14,909	56
57	Water Heater	2010	4,040		10	337	337	4,040	57
58	Cooling Tower Fan	2011	4,554		10	455	455	4,135	58
59	Seal & Stripe Parking Lot	2010	4,839		25	194	194	1,872	59
60	Heat Pumps	2012	5,218		10	522	522	4,349	60
61	Replace Interior/Exterior Doors	2013	6,951		10	695	695	4,923	61
62	Purchase & Install 8 Doors	2013	3,476		40	87	87	589	62
63	Water Heater	2015	6,699		10	670	670	3,518	63
64	A/C'S/Heat Pumps	2015	5,310		10	532	532	2,878	64
65	Landscaping	2013	3,310		25	132	132	881	65
66	Landscaping	2015	5,375		25	215	215	1,075	66
67	A/C Units	2015	14,019		10	1,402	1,402	6,893	67
68	3 Heat Pumps	2016	8,240		10	824	824	3,571	68
69	Cooling Tower Coil	2016	29,740		10	2,974	2,974	12,144	69
70	TOTAL (lines 4 thru 69)		$ 3,584,581	$		$ 12,021	$ 12,021	$ 3,508,914	70

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,584,581	$		$ 12,021	$ 12,021	$ 3,508,914	1
2	7 A/C Units	2016	17,813		10	1,782	1,782	7,126	2
3	Shrubs, Plastic, Rock & Mulch for Flower Beds	2017	10,280		25	411	411	1,337	3
4	TV Mounts	2016	2,579		7	368	368	1,288	4
5	Complete Renovation of rooms 415-418, Carpentry, Flooring								5
6	Painting, Handrails, Plumbing, and Electrical	2016	55,490		15	3,700	3,700	12,948	6
7	Flooring - Utility Room, Laundry Room & Break Rooms	2017	19,342		15	1,290	1,290	3,958	7
8	Tile - Lobby, Nurse Stations & Dining Rooms	2017	7,598		15	508	508	1,523	8
9	Heat Pump	2016	10,900		10	1,090	1,090	4,178	9
10	Evaporator Coils for Cooling Tower	2016	1,772		10	177	177	679	10
11	10 A/C/Heating E-Tax Units	2016	15,496		10	1,550	1,550	5,554	11
12	Install 5 Heater Units	2016	3,443		10	344	344	1,204	12
13	Heat Pumps for Dining Room & 200 Hallway	2017	22,600		10	2,260	2,260	6,968	13
14	New Boiler	2017	57,930		10	5,794	5,794	18,829	14
15	Install PTACs - Century	2017	3,707		10	372	372	1,115	15
16	Purchase & Install 51 E-Tac Units	2017	138,355		10	13,836	13,836	41,508	16
17	New Dry Pendants & Pipes for Sprinkler System	2017	26,993		10	2,700	2,700	8,099	17
18	Hot Water Heater	2017	10,678		10	1,068	1,068	3,204	18
19	Heat Pump - Laundry Hallway	2017	12,796		10	1,280	1,280	3,840	19
20	Carpet/Tile/Painting - Nurses Call Station	1993	20,471		7			20,471	20
21	Painting/Wallpaper	1994	15,422		7			15,422	21
22	Painting/Wallpaper/Tile	1995	25,375		7			25,375	22
23	Shelving	1995	2,186		7			2,186	23
24	New Upholstery	1995	513		7			513	24
25	Design Work	1995	128		7			128	25
26	Carpeting	1996	5,580		7			5,580	26
27	Painting/Tiling	1996	6,383		7			6,383	27
28	Painting	1997	3,025		7			3,025	28
29	Tile & Base 2 Rooms	1997	1,400		7			1,400	29
30	2 Oak Doors	1997	803		7			803	30
31	Carpet & Installation	1998	7,950		7			7,951	31
32	Shower Renovations	1998	16,869		7			16,869	32
33	Paint/Wallpaper/Tile Removal	1998	1,833		7			1,833	33
34	TOTAL (lines 1 thru 33)		$ 4,110,291	$		$ 50,551	$ 50,551	$ 3,740,211	34

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,110,291	$		$ 50,551	$ 50,551	$ 3,740,211	1
2	Shower Room	1998	18,424		7			18,424	2
3	Wallpaper	1998	273		7			273	3
4	Painting	1998	970		7			970	4
5	Wallpaer	1998	5,103		7			5,103	5
6	Carpet/Installation	1998	5,106		7			5,106	6
7	Phone System	1998	8,703		7			8,703	7
8	Wallpaper	1998	4,450		7			4,450	8
9	Drapery	2000	31,964		7			31,964	9
10	Computer Cabling	2000	2,392		7			2,392	10
11	Painting	2001	18,240		7			18,240	11
12	Cabling	2001	606		7			606	12
13	Carpet/Installation	2002	1,150		7			1,150	13
14	Wallcovering	2004	3,554		7			3,554	14
15	Drywall	2004	6,594		7			6,594	15
16	Shelving	2004	2,271		7			2,271	16
17	Tile & Base 2 Rooms	2004	5,918		7			5,918	17
18	Floor Tile & Base	2005	4,203		7			4,203	18
19	Parking Lot Striping & Sealing	2005	3,993		7			3,993	19
20	Repair Water Damaged Rooms	2005	6,141		7			6,141	20
21	Drapes	2006	4,666		7			4,666	21
22	Carpet	2009	13,379		7			13,220	22
23	Water Heater	2011	4,780		7			4,724	23
24	Telephone System	2011	27,729		7			27,424	24
25	Cooling Tower Fan Motor Repair	2011	4,554		7			4,554	25
26	3 Door Freezer	2013	5,056		7			5,056	26
27	Flooring - 400, 500 corridors, 100/200 & 3400/500 nurses station	2013	4,916	527	7	527		4,856	27
28	(cont.) main & assisted dining rooms, mechanical wing								28
29	(cont.) therapy wing, 500 corridor bathing suite, rooms 501								29
30	(cont.) 503, 402, 404, 516 & 517								30
31	Lobby Floor	2014	2,200	314	7	314		1,779	31
32	Lobby Walls	2014	3,400	486	7	486		2,673	32
33	Parking Lot Paved	2015	4,980	712	7	712		3,557	33
34	TOTAL (lines 1 thru 33)		$ 4,316,006	$ 2,039		$ 52,590	$ 50,551	$ 3,942,775	34

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,316,006	$ 2,039		$ 52,590	$ 50,551	$ 3,942,775	1
2	PTAC Units and Installation	2017	14,209		10	1,421	1,421	3,908	2
3	Paging System	2017	4,952		10	496	496	1,363	3
4	Replace Make Up Air Unit in Kitchen	2017	32,040		10	3,204	3,204	8,811	4
5	ETAC Units	2017	10,811		10	1,080	1,080	2,971	5
6	Expansion Valve	2017	1,283		10	128	128	341	6
7	Dish Machine Motor Assembly	2017	3,014		10	300	300	801	7
8	PTAC Installation	2017	3,200		10	320	320	827	8
9	Complete remodel of all rooms except 415-418, Carpentry	2017	1,571,704		15	104,780	104,780	270,640	9
10	Flooring, Painting, Handrails, Plumbing, and Electrical								10
11	Patching walls from PTAC Installations	2017	28,158		10	1,878	1,878	5,166	11
12	Fire Sprinkler System	2017	71,177		10	7,116	7,116	18,962	12
13	Relocate A/C to Reception Area	2017	16,875		10	1,688	1,688	4,642	13
14	White Oak Construction	2017	4,729		15	316	316	868	14
15	Nurse Call System	2018	104,893		10	10,488	10,488	22,725	15
16	Complete remodel of all shower rooms - Carpentry,	2018	219,261		15	14,616	14,616	34,105	16
17	Flooring, Painting, Plumbing, Electrical								17
18	A/C Kitchen	2018	28,528		10	2,854	2,854	5,708	18
19	Door Contacts - Security	2018	447		10	46	46	88	19
20	Combustion Air System	2018	6,180		10	618	618	1,082	20
21	Tower Motor	2018	5,895		10	590	590	885	21
22	Sprinkler Heads	2018	1,924		7	70	70	105	22
23	Ceiling Mounted Heat Pump in 300 Hallway	2019	9,570		10	958	958	1,118	23
24	Water Heater	2019	3,780		10	378	378	378	24
25	Kitchen Remodel - Flooring, Drywall, Paint, Doors	2018	102,042		15	6,804	6,804	10,206	25
26	Mechanical Room Flooring	2018	8,584		15	572	572	858	26
27	Patient Room Ceiling Drywall and Paint	2019	2,450		15	162	162	230	27
28	Hallway off Main Dining Room Flooring	2020	3,890		15	237	237	237	28
29	Foot Fence	2020	3,146		15	175	175	175	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,578,748	$ 2,039		$ 213,885	$ 211,846	$ 4,339,975	34

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	$ 588,800	$ 17,388	$ 88,835	$ 71,447	10	$ 313,155	71
72	Current Year Purchases	24,571	640	987	347	10	987	72
73	Fully Depreciated Assets	405,586					395,800	73
74								74
75	TOTALS	$ 1,018,957	$ 18,028	$ 89,822	$ 71,794		$ 709,942	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2014 Bus	2014	$ 36,777	$ 5,254	$ 5,254	$	7	$ 29,773	76
77										77
78										78
79										79
80	TOTALS			$ 36,777	$ 5,254	$ 5,254	$		$ 29,773	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)	$ 7,760,513	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,321	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 308,961	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 283,640	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,079,690	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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 Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2	hrs				50		50	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				170,294		170,294	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): PT, OT, ST, Lab, Xray	39, 3				671,601			671,601	13
14	TOTAL			$		$ 671,601	$ 170,344		$ 841,945	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 Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/20 (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	$ 556,265	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 250,000)	914,883		3
4	Supply Inventory (priced at)	5,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	52,895		6
7	Other Prepaid Expenses	43,085		7
8	Accounts Receivable (owners or related parties)	400,000		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,972,128	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	313,654		15
16	Equipment, at Historical Cost	170,363		16
17	Accumulated Depreciation (book methods)	(448,800)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	2,467		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 37,684	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,009,812	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 200,014	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	233,310		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,262		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	15,131		36
37	PPP Loan	792,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,252,717	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,252,717	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 757,095	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,009,812	$	48

*(See instructions.)

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 733,320	1
2	Restatements (describe):		2
3	**Prior Adjustments**	(56,391)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 676,929	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	80,166	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)**	$ 80,166	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)**	$ 757,095	24 *

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

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	$ 7,513,324	1
2	Discounts and Allowances for all Levels	(1,474,641)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,038,683	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,256,898	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,256,898	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	2,025	13
14	Non-Patient Meals	749	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,774	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	CARES Grant Income	486,670	28
28a	Miscellaneous	3,356	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 490,026	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,788,381	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,305,541	31
32	Health Care	3,422,080	32
33	General Administration	1,237,847	33
	B. Capital Expense		
34	Ownership	642,612	34
	C. Ancillary Expense		
35	Special Cost Centers	841,895	35
36	Provider Participation Fee	258,240	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,708,215	40
41	**Income before Income Taxes (line 30 minus line 40)****	80,166	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 80,166	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,944,294	44
45	Private Pay - Net Inpatient Revenue	1,614,846	45
46	Medicare - Net Inpatient Revenue	1,136,382	46
47	Other-(specify) Managed Care/Private Insurance	343,161	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,038,683	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 Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

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	2,005	2,081	$ 83,890	$ 40.31	1
2	Assistant Director of Nursing	1,843	1,916	72,101	37.63	2
3	Registered Nurses	8,565	9,190	302,177	32.88	3
4	Licensed Practical Nurses	37,182	39,637	1,111,103	28.03	4
5	CNAs & Orderlies	74,169	78,309	1,133,446	14.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,937	5,146	107,336	20.86	8
9	Activity Director					9
10	Activity Assistants	5,316	5,503	62,949	11.44	10
11	Social Service Workers	3,962	4,097	76,393	18.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,323	22,804	275,546	12.08	15
16	Dishwashers					16
17	Maintenance Workers	3,911	4,164	102,656	24.65	17
18	Housekeepers	17,603	18,662	202,650	10.86	18
19	Laundry	5,229	5,595	55,999	10.01	19
20	Administrator	2,148	2,243	116,723	52.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,329	11,330	219,324	19.36	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	1,897	2,038	27,225	13.36	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,419	212,715	$ 3,949,518 *	$ 18.57	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	$ 9,355	1, 3	35
36	Medical Director	Contract	14,400	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	3,780	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	2,688	11, 3	44
45	Social Service Consultant	Contract	2,688	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,911		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	298	$ 15,832	10, 3	50
51	Licensed Practical Nurses	612	19,344	10, 3	51
52	Certified Nurse Assistants/Aides	2,240	54,980	10, 3	52
53	TOTAL (lines 50 - 52)	3,150	$ 90,156		53

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gail Kimmle	Administrator	0	$ 116,723
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 116,723

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting/Consulting	$ 8,100
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 8,100

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 137,357
Unemployment Compensation Insurance	43,403
FICA Taxes	292,278
Employee Health Insurance	125,333
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Drug Tests	1,185
Uniforms	1,526
Employee Relations	3,856
TOTAL (agree to Schedule V, line 22, col.8)	$ 604,938

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

Description	Line #	Amount
Section N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	18,319
Health Care Worker Background Check	
(Indicate # of checks performed)	1,228
Patient Background Checks	1,541
IHCA Allowable Fees	6,236
Licenses & Fees	3,033
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,347

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,898
Seminar Expense	255
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,153

**See instructions.

Facility Name & ID Number Mercy Rehab and Care Center # 0032680 Report Period Beginning: 07/01/19 Ending: 06/30/20

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. **6236 Illinois Health Care Association**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,148** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **258,240**
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? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **749**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.