



Facility Name & ID Number A MERKLE C KNIPPRATH N H

# 0021832 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	15	Sheltered Care (SC)	15	5,475	5
6		ICF/DD 16 or Less			6
7	114	TOTALS	114	41,610	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,988	8,088	2,758	18,834	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		4,204		4,204	12
13	DD 16 OR LESS					13
14	TOTALS	7,988	12,292	2,758	23,038	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.37%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A-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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

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

Date started 10/6/75

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 10/01/13 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 99 and days of care provided 2,560

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	59,156	22,967	268,706	350,829	350,829		350,829		1	
2	Food Purchase		158,677		158,677	158,677		158,677		2	
3	Housekeeping	90,539	22,505	34	113,078	113,078		113,078		3	
4	Laundry		8,926	6,307	15,233	15,233		15,233		4	
5	Heat and Other Utilities			160,133	160,133	160,133		160,133		5	
6	Maintenance	80,833	5,739	50,906	137,478	137,478		137,478		6	
7	Other (specify):* <b>Pastoral Care</b>	29,033	599	3,504	33,136	33,136		33,136		7	
8	<b>TOTAL General Services</b>	<b>259,561</b>	<b>219,413</b>	<b>489,590</b>	<b>968,564</b>	<b>968,564</b>		<b>968,564</b>		<b>8</b>	
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,300	14,300	14,300		14,300		9	
10	Nursing and Medical Records	1,038,333	109,107	20,367	1,167,807	1,167,807		1,167,807		10	
10a	Therapy			288,259	288,259	288,259		288,259		10a	
11	Activities	57,208	4,935	11,697	73,840	73,840		73,840		11	
12	Social Services	10,729		357	11,086	11,086		11,086		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	<b>1,106,270</b>	<b>114,042</b>	<b>334,980</b>	<b>1,555,292</b>	<b>1,555,292</b>		<b>1,555,292</b>		<b>16</b>	
	<b>C. General Administration</b>										
17	Administrative	242,881	(951)		241,930	241,930	(1)	241,929		17	
18	Directors Fees									18	
19	Professional Services			4,310	4,310	4,310		4,310		19	
20	Dues, Fees, Subscriptions & Promotions			21,158	21,158	21,158	(1,177)	19,981		20	
21	Clerical & General Office Expenses			15,169	15,169	15,169		15,169		21	
22	Employee Benefits & Payroll Taxes			518,259	518,259	518,259		518,259		22	
23	Inservice Training & Education									23	
24	Travel and Seminar			1,234	1,234	1,234		1,234		24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			25	25	25		25		26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	<b>242,881</b>	<b>(951)</b>	<b>560,155</b>	<b>802,085</b>	<b>802,085</b>	<b>(1,178)</b>	<b>800,907</b>		<b>28</b>	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,608,712</b>	<b>332,504</b>	<b>1,384,725</b>	<b>3,325,941</b>	<b>3,325,941</b>	<b>(1,178)</b>	<b>3,324,763</b>		<b>29</b>	

\*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 &amp; ID Number

A MERKLE C KNIPPRATH N H

#0021832

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			205,106	205,106	205,106	24,730	229,836				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,530	1,530	1,530		1,530				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			206,636	206,636	206,636	24,730	231,366				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			102,065	102,065	102,065		102,065				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			196,546	196,546	196,546		196,546				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			298,611	298,611	298,611		298,611				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,608,712	332,504	1,889,972	3,831,188	3,831,188	23,552	3,854,740				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 **A MERKLE C KNIPPRATH N H**

# **0021832**

Report Period Beginning: **01/01/2014**

Ending: **12/31/2014**

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	24,984	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,177)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 23,807		\$	30

<b>BHF USE ONLY</b>						
48		49		50		51
						52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 23,807		37

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

A MERKLE C KNIPPRATH N H

ID# 0021832

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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
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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number A MERKLE C KNIPPRATH N H# 0021832

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	(1)	0	0	0	0	0	0	0	0	(1)	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	(1,177)	0	0	0	0	0	0	0	0	0	0	(1,177)	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(1,177)	0	(1)	0	0	0	0	0	0	0	0	(1,178)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(1,177)	0	(1)	0	0	0	0	0	0	0	0	(1,178)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number A MERKLE C KNIPPRATH N H# 0021832

Report Period Beginning:

01/01/2014 Ending:12/31/2014

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	24,984	0	(254)	0	0	0	0	0	0	0	0	24,730	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>24,984</b>	<b>0</b>	<b>(254)</b>	<b>0</b>	<b>24,730</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	23,807	0	(255)	0	0	0	0	0	0	0	0	23,552	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Presence Our Lady of Victory	Bourbonnais	Presence Service Corp	Various	Physician's Clinics
		Presence Pine View Care Center	St. Charles	Presence Fortin Villa I	Bourbonnais	Childrens Center
		Presence Cor Mariae Center	Rockford	Presence Fox Knoll	Aurora	Retirement Comm
		Presence St. Joseph Center	Freeport	Presence Health	Frankfort	Parent Company
		Presence McAuley Manor	Aurora	Presence Home Care	Various	Home Health
		Presence St. Anne Center	Rockford	Presence Care @ Hom	Various	Home Equipment
		Presence Villa Franciscan	Joliet	Presence Hospice	Various	Hospice

**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	2 Food	\$	Presence Life Connections	100.00%	\$ 0	\$
2	V	5 Utilities		Presence Life Connections	100.00%	0	
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	0	
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	0	
5	V	17 Admin - Misc. Other		Presence Life Connections	100.00%	0	
6	V	17 Administrative Salaries	1	Presence Life Connections	100.00%	1	
7	V	19 Professional Services		Presence Life Connections	100.00%	0	
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	0	
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	0	
10	V	22 Employee Benefits		Presence Life Connections	100.00%	0	
11	V	23 Education/Conference		Presence Life Connections	100.00%	0	
12	V	24 Travel		Presence Life Connections	100.00%	0	
13	V	26 Insurance		Presence Life Connections	100.00%	0	
14	Total		\$ 1			\$ 1	\$ *

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 Depreciation	\$	Presence Life Connections	100.00%	\$ 0	\$ 15
16	V	32 Interest		Presence Life Connections	100.00%	0	16
17	V	34 Rent - Facility		Presence Life Connections	100.00%	0	17
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	0	18
19	V	17 Admin Salaries		Presence Health	100.00%	0	19
20	V	22 Employee Benefits		Presence Health	100.00%	0	20
21	V	30 Depreciation	357	Presence Health	100.00%	103	(254)
22	V	34 Rent Facility		Presence Health	100.00%	0	22
23	V	17 Admin Consulting,Other	1	Presence Health	100.00%	0	(1)
24	V	17 Information Systems Salaries		Presence Health	100.00%	0	24
25	V	17 Information Systems - Other		Presence Health	100.00%	0	25
26	V	17 Admin Salaries		Presence Health	100.00%	0	26
27	V	17 Information Systems Salaries		Presence Health	100.00%	0	27
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%	0	28
29	V	17 Admin Consulting,Other		Presence Health	100.00%	0	29
30	V	32 Admin - Interest Expense		Presence Health	100.00%	0	30
31	V	39 Ancillary Services - Other	102,065	Presence Senior Services Pharmacy	100.00%	102,065	
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$ 102,423			\$ 102,168	\$ * (255)

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

Facility Name &amp; ID Number

A MERKLE C KNIPPRATH N H

# 0021832

Report Period Beginning:

01/01/2014

Ending:

12/31/2014

## 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	Jean Blake	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Nancy T. Dowd	BOD	Presence Ballard Nursing Center	Des Plaines	Laverna Terrace Hous	Avilla, IN	Independent Living	2
3	Patricia Gomez	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Presence Heritage Lod	Kankakee	Supportive Living	3
4	James C. Hagen	BOD	Presence Nazarethville	Des Plaines	Presence Life Connect	Mokena	Management Comp	4
5	Lucia Jones	BOD	Presence Resurrection Life Center	Chicago	Presence Senior Servic	Kankakee	Pharmacy	5
6	Theresa Kwiatkowski	BOD	Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence St. Joseph Ac	Freeport	Adult Day Care	6
7	Joseph G. Hugar	BOD	Presence St Andrew Life Center	Niles	Presence Heritage Day	Kankakee	Adult Day Care	7
8	John Larson	BOD	Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Vincent	Freeport	Community Living	8
9	Sr. Marie Mason	BOD	Presence Villa Scalabrini Nursing & Rehab Cen	Northlake	Presence Behavioral H	Broadview	Parent	9
10	Sallie Miller	BOD			Presence Holy Family	Des Plaines	Hospital	10
11	Phyllis Nichols	BOD			Presence Bethlehem W	LaGrange Park	Independent Living	11
12	Lawrence R. Pankau	BOD			Presence Our Lady of	Chicago	Hospital	12
13	Tim Phillippe	BOD			Presence Casa San Ca	Northlake	Independent Living	13
14	Thomas E. Smith	BOD			Presence Ambulatory	Various	Parent	14
15					Resurrection Developr	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Ministries of New York		Nursing Home	20
21					Resurrection Services	Des Plaines	Parent	21
22					Presence Saint Francis	Evanston	Hospital	22
23					Presence Saint Joseph	Chicago	Hospital	23
24					Presence Saints Mary	Chicago	Hospital	24
25					Resurrection Retireme	Chicago	Independent Living	25
26					Resurrection Universit	Chicago	College	26
27					Presence Health Partn	Various	Parent	27
28					Presence Properties PI	Frankfort	Parent	28
29					Presence Ventures, Inc	Frankfort	Parent	29
30					Presence Heritage Est	Kankakee	Independent Living	30

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

## VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H

# 0021832

Report Period Beginning:

01/01/2014

Ending: 2/31/2014

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

Name of Related Organization

Presence Life Connections

Street Address

18927 Hickory Creek Dr, Ste 300

City / State / Zip Code

Mokena, IL 60448

Phone Number

( 708-478-7900

Fax Number

( 708-478-5387

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income 4,729,991	29	\$ 14,111		1	\$ 0	1
2	5	Utilities	Management Fee Income 4,729,991	29	58,852		1	0	2
3	6	Maintenance - Other	Management Fee Income 4,729,991	29	16,970		1	0	3
4	11	Activities-Special Events	Management Fee Income 4,729,991	29	9,560		1	0	4
5	17	Admin - Misc. Other	Management Fee Income 4,729,991	29	231,804		1	0	5
6	17	Administrative Salaries	Management Fee Income 4,729,991	29	4,162,833	4,162,833	1	1	6
7	19	Professional Services	Management Fee Income 4,729,991	29	433,914		1	0	7
8	20	Dues,Subscriptions	Management Fee Income 4,729,991	29	149,744		1	0	8
9	21	Clerical Supplies	Management Fee Income 4,729,991	29	38,881		1	0	9
10	22	Employee Benefits	Management Fee Income 4,729,991	29	814,191		1	0	10
11	23	Education/Conference	Management Fee Income 4,729,991	29	5,968		1	0	11
12	24	Travel	Management Fee Income 4,729,991	29	37,983		1	0	12
13	26	Insurance	Management Fee Income 4,729,991	29	(5,634)		1	0	13
14	30	Depreciation	Management Fee Income 4,729,991	29	(628,443)		1	0	14
15	32	Interest	Management Fee Income 4,729,991	29	0		1	0	15
16	34	Rent - Facility	Management Fee Income 4,729,991	29	443,738		1	0	16
17	35	Rent - Equipment	Management Fee Income 4,729,991	29	26,658		1	0	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,811,130	\$ 4,162,833		\$ 1	25

Facility Name & ID Number A MERKLE C KNIPPRATH N H

# 0021832 Report Period Beginning: 01/01/2014

Ending: 2/31/2014

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

Name of Related Organization Presence Health  
 Street Address 100 North River Road  
 City / State / Zip Code Des Plaines, IL 60016  
 Phone Number ( 815-806-2327  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	5,067,405	17	\$ 1,375,283	\$ 1,375,283	1	\$	1
2	22	Employee Benefits	Operating Expense	5,067,405	17	834,149		1		2
3	30	Depreciation	Operating Expense	1,479,052	17	803,889		357		3
4	34	Rent Facility	Operating Expense	5,067,405	17	244,378		1		4
5	17	Admin Consulting,Other	Operating Expense	5,067,405	17	5,074,164		1		5
6	17	Information Systems Salaries	Operating Expense	5,067,405	17	487,675	487,675	1		6
7	17	Information Systems - Other	Operating Expense	5,067,405	17	1,742,443		1		7
8	17	Admin Salaries	Direct Cost	5,067,405	17	403,064	403,064	1		8
9	17	Information Systems Salaries	Direct Cost	5,067,405	17	555,758	555,758	1		9
10	6	Information Systems - Equip Mai	Direct Cost	5,067,405	17	292,852		1		10
11	17	Admin Consulting,Other	Direct Cost	5,067,405	17	237,106		1		11
12	32	Admin - Interest Expense	Direct Cost	5,067,405	17	1,193,207		1		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					\$ 13,243,968	\$ 2,821,780		\$	195

Facility Name & ID Number A MERKLE C KNIPPRATH N H

# 0021832 Report Period Beginning: 01/01/2014

Ending: 2/31/2014

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

Name of Related Organization Presence Senior Services Pharmacy  
 Street Address 670 Noth Convent Street  
 City / State / Zip Code Bourbonnais, IL 60614  
 Phone Number ( 815-936-3644  
 Fax Number ( 815-936-3238

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 102,065	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				\$	\$		\$ 102,065	25



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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 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 2014 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			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:	2009 _____	8	<b>FOR BHF USE ONLY</b>		
	2010 _____	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
	2011 _____	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2012 _____	11	15	LESS REFUND FROM LINE 6 \$	15
	2013 _____	12	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.**

## 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME A MERKLE C KNIPPRATH N H COUNTY IROQUOIS

FACILITY IDPH LICENSE NUMBER 0021832

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

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

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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.**

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 53,919 B. General Construction Type: Exterior BRICK Frame MASONARY Number of Stories 1

C. Does the Operating Entity?  (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?  (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).

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

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>1,730,560</u>	<u>1975</u>	<u>\$ 24,225</u>	<u>1</u>
2	<u>FARM/ILU</u>	<u>995,072</u>	<u>1975</u>	<u>32,775</u>	<u>2</u>
3	<b>TOTALS</b>	<b>2,725,632</b>		<b>\$ 57,000</b>	<b>3</b>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99	2013	1975	\$ 773,036	\$ 19,326	40	\$ 19,326	\$	\$ 763,373	4
5	15	2013	1992							5
6										6
7										7
8										8
	Improvement Type**									
9	VARIOUS		1986	324,830	8,121	40	8,121		236,771	9
10	VARIOUS		1992	1,465,015	41,279	30	41,279		949,415	10
11	VARIOUS		1995	177,260	6,363	24	6,363		126,067	11
12	VARIOUS		1998	7,339	367	20	367		6,055	12
13	VARIOUS		2000	53,780	2,216	20	2,216		32,126	13
14	VARIOUS		2001	12,094	806	20	806		10,885	14
15	VARIOUS		2002	69,025	3,124	15	3,124		39,049	15
16	VARIOUS		2003	52,773	2,639	20	2,639		30,344	16
17	VARIOUS		2004	54,894	2,924	13	2,924		50,213	17
18	VARIOUS		2005	3,058	230	13	230		2,187	18
19	VARIOUS		2006	20,027	1,567	14	1,567		13,315	19
20	VARIOUS		2007	32,768	2,020	18	2,020		15,151	20
21	VARIOUS		2008	119,775	8,400	14	8,400		54,602	21
22	VARIOUS		2009	87,276	5,019	16	5,019		27,603	22
23										23
24	FLOORING - NURSING CHART ROOM		2012	3,155	316	10	316		789	24
25										25
26	WIRELESS INTERNET		2013	73,173	7,317	10	7,317		10,162	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	INSTALLATION OF NEW CARPET, COUNTERS & (contd)	2014	\$ 262,443	\$ 8,748	15	\$ 17,496	\$ 8,748	\$ 8,748	37
38	CABINETS IN ENTRYWAY, HALLWAYS & DINING ROOM								38
39	FURNACE FOR EAST HALLWAY	2014	2,613	87	15	174	87	87	39
40	8 PTAC AC UNITS & INSULATED WALL SLE	2014	7,124	356	10	712	356	356	40
41	PAINTING TO 6 UNITS AND COMMON AREA	2014	4,000	400	5	800	400	400	41
42	THERAPY/ACTIVITY ROOM FLOORING, ELEC	2014	14,636	488	15	976	488	488	42
43	ELECTRICAL PROBLEMS WITH AC UNITS IN	2014	3,826	191	10	383	192	191	43
44	THERAPY ROOM PTAC UNITS	2014	3,495	175	10	350	175	175	44
45	PTAC (A/C) UNIT	2014	45,000	2,250	10	4,500	2,250	2,250	45
46	NEW ROOF FOR MKC BUILDING	2014	247,770	6,195	20	12,389	6,194	6,195	46
47	LIGHTING & FIXTURES FOR COMMON AREA/HALLWAYS	2014	10,866	362	15	724	362	362	47
48	INSTALLATION OF LIGHTING IN COMMON AREA/HALLS	2014	12,788	426	15	853	427	426	48
49	PATIENT TRANSPORTATION SLINGS AND EQ	2014	16,628	416	20	831	415	416	49
50	GAS FURNACE	2014	3,400	113	15	227	114	113	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)		\$ 3,963,867	\$ 132,241		\$ 152,448	\$ 20,207	\$ 2,388,314	70

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

Facility Name & ID Number **A MERKLE C KNIPPRATH N H**

# **0021832**

Report Period Beginning:

**01/01/2014**

Ending:

**12/31/2014**

**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	\$ 1,147,874	\$ 66,882	\$ 66,882	\$	11	\$ 66,883	71
72	Current Year Purchases	128,094	4,777	9,554	4,777	12	4,777	72
73	Fully Depreciated Assets	168,221	1,206	1,206		12	1,206	73
74	Home Office Allocation		(254)	(254)				74
75	<b>TOTALS</b>	\$ 1,444,189	\$ 72,611	\$ 77,388	\$ 4,777		\$ 72,866	75

**D. Vehicle Costs. (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 5,465,056	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 204,852	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 229,836	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 24,984	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,461,180	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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	Home Office Allocation				0			5
6								6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ 1,530 Description: Administration \$1322, Nursing \$208

(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.

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	1,822	\$ 120,935	\$	1,822	\$ 120,935	1	
2	Licensed Speech and Language Development Therapist	10a,3	hrs		357	24,182		357	24,182	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a,3	hrs		2,181	144,012		2,181	144,012	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 prescripts				102,065		102,065	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	<b>TOTAL</b>			\$	4,360	\$ 289,129	\$ 102,065	4,360	\$ 391,194	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 **A MERKLE C KNIPPRATH N H**# **0021832**Report Period Beginning: **01/01/2014**

Ending:

**12/31/2014****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2014**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 17,950,359	\$	1
2	Cash-Patient Deposits	72,337		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	19,407,606		3
4	Supply Inventory (priced at )	1,093,010		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,333,260		7
8	Accounts Receivable (owners or related parties)	164,572		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 40,021,144	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	12,430,526		12
13	Land	4,046,124		13
14	Buildings, at Historical Cost	102,077,391		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	24,435,524		16
17	Accumulated Depreciation (book methods)	(71,565,717)		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):	178,882		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 71,602,730	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 111,623,874	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 8,937,682	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,520,349		28
29	Short-Term Notes Payable	80,363		29
30	Accrued Salaries Payable	3,587,416		30
31	Accrued Taxes Payable (excluding real estate taxes)	165,802		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,802,942		32
33	Accrued Interest Payable	6,892		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Party</u>	20,821,819		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 36,923,265	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	813,772		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	246,530		42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>	438,744		43
44	<u>Deferred Lease Payable</u>	33,828		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,532,874	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 38,456,139	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 73,167,735	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 111,623,874	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 74,695,879	1
2	Restatements (describe):		2
3			3
4	Adj to reconcile consolidated equity & consolidated income	(1,901,671)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,794,208	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	95,053	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	389,214	11
12	Expenditures for Specific Purposes	(110,740)	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)	\$ 373,527	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 73,167,735	24 *

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

**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.

		1	
<b>I. Revenue</b>		<b>Amount</b>	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,250,119	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,250,119	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	489,194	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 489,194	8
<b>C. Other Operating Revenue</b>			
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	10,833	13
14	Non-Patient Meals	8,651	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	133,928	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 153,412	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	17,876	24
25	Interest and Other Investment Income***	(12,858)	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,018	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Purchase Rebates</b>	6,700	28
28a	<b>Other Misc Income</b>	21,798	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 28,498	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,926,241	30

		2	
<b>II. Expenses</b>		<b>Amount</b>	
<b>A. Operating Expenses</b>			
31	General Services	968,564	31
32	Health Care	1,555,292	32
33	General Administration	802,085	33
<b>B. Capital Expense</b>			
34	Ownership	206,636	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	102,065	35
36	Provider Participation Fee	196,546	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,831,188	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	95,053	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 95,053	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,141,736	44
45	Private Pay - Net Inpatient Revenue	1,291,644	45
46	Medicare - Net Inpatient Revenue	564,857	46
47	Other-(specify) <u>Insurance</u>	53,706	47
48	Other-(specify)	198,177	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,250,120	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No 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 **A MERKLE C KNIPPRATH N H**

# **0021832**

Report Period Beginning: **01/01/2014**

Ending:

**12/31/2014**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,528	1,916	\$ 65,665	\$ 34.27	1
2	Assistant Director of Nursing	929	959	30,996	32.32	2
3	Registered Nurses	7,542	8,189	221,546	27.05	3
4	Licensed Practical Nurses	11,041	11,883	256,627	21.60	4
5	CNAs & Orderlies	40,007	42,189	458,306	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,887	2,086	26,898	12.89	9
10	Activity Assistants	2,389	2,540	30,310	11.93	10
11	Social Service Workers	833	910	10,729	11.79	11
12	Dietician					12
13	Food Service Supervisor	537	659	10,850	16.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,218	5,079	54,836	10.80	15
16	Dishwashers					16
17	Maintenance Workers	4,335	4,599	79,496	17.29	17
18	Housekeepers	7,731	8,296	90,539	10.91	18
19	Laundry					19
20	Administrator	1,847	2,086	93,849	44.99	20
21	Assistant Administrator					21
22	Other Administrative	8,080	8,532	114,365	13.40	22
23	Office Manager					23
24	Clerical					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					31
32	Other Health C: Admissions	1,823	1,943	34,667	17.84	32
33	Other(specify) Pastoral Care	1,028	1,069	29,033	27.16	33
34	TOTAL (lines 1 - 33)	95,755	102,935	\$ 1,608,712 *	\$ 15.63	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	59	\$ 3,693	1,3	35
36	Medical Director	Monthly	14,300	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	\$6.40/resident	3,648	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	21	1,863	11,2	44
45	Social Service Consultant	4	357	12,2	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	84	\$ 23,861		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	398	\$ 23,802	10,2	50
51	Licensed Practical Nurses	76	1,850	10,2	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	474	\$ 25,652		53



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number A MERKLE C KNIPPRATH N H

# 0021832

Report Period Beginning: 01/01/2014 Ending: 12/31/2014

## 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. Life Services Network \$2895
- (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? N/A
- (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? 9 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,128 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. \$ 196,546  
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. \$ None Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,651
- (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? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG
- (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.