

		FOR BHF USE					

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**2015**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2015)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0021832</u></p> <p><b>Facility Name:</b> <u>A MERKLE C KNIPPRATH N H</u></p> <p><b>Address:</b> <u>1190 E 2900 NORTH RD</u> <u>CLIFTON</u> <u>60927</u>  Number City Zip Code</p> <p><b>County:</b> <u>IROQUOIS</u></p> <p><b>Telephone Number:</b> <u>815-694-2306</u> <b>Fax #</b> <u>815-694-2818</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>10-01-13</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> <u>501C3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>GEORGE VIEU</u> <b>Telephone Number:</b> <u>708-478-7943</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501C3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/15</u> to <u>12/31/15</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>MICHAEL R. GORDON</u> (Title) <u>CFO, VICE PRESIDENT OF FINANCE</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) _____ Fax # ( ) _____</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 <span style="float: right;">Phone # (217) 782-1630</span></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>MICHAEL R. GORDON</u> (Title) <u>CFO, VICE PRESIDENT OF FINANCE</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
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Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____																												

Facility Name & ID Number A MERKLE C KNIPPRATH N H

# 0021832 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>15</u>	Sheltered Care (SC)	<u>15</u>	<u>5,475</u>	5
6		ICF/DD 16 or Less			6
7	<u>114</u>	TOTALS	<u>114</u>	<u>41,610</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	<u>10,476</u>	<u>7,050</u>	<u>3,191</u>	<u>20,717</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>5,331</u>		<u>5,331</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,476</u>	<u>12,381</u>	<u>3,191</u>	<u>26,048</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.60%

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 10-06-75

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 3,058

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: 12-31-15 Fiscal Year: 12-31-15

\* 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		15,159	363,718	378,877	378,877		378,877			1
2	Food Purchase		159,615		159,615	159,615	(7,475)	152,140			2
3	Housekeeping	83,857	20,468	3,918	108,243	108,243		108,243			3
4	Laundry		9,801	5,047	14,848	14,848		14,848			4
5	Heat and Other Utilities			135,666	135,666	135,666	905	136,571			5
6	Maintenance	94,627	30,082	73,389	198,098	198,098	2,027	200,125			6
7	Other (specify):* Pastoral	25,845	757	2,886	29,488	29,488		29,488			7
8	<b>TOTAL General Services</b>	204,329	235,882	584,624	1,024,835	1,024,835	(4,543)	1,020,292			8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000	12,000		12,000			9
10	Nursing and Medical Records	1,073,572	113,127	33,126	1,219,825	1,219,825		1,219,825			10
10a	Therapy	105,159		517,603	622,762	622,762		622,762			10a
11	Activities	81,334	5,965	9,556	96,855	96,855	216	97,071			11
12	Social Services	31,553		181	31,734	31,734		31,734			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*	95,953			95,953	95,953		95,953			15
16	<b>TOTAL Health Care and Programs</b>	1,387,571	119,092	572,466	2,079,129	2,079,129	216	2,079,345			16
	<b>C. General Administration</b>										
17	Administrative	276,897	16,207	156,178	449,282	449,282	(36,742)	412,540			17
18	Directors Fees										18
19	Professional Services			9,910	9,910	9,910	16,258	26,168			19
20	Dues, Fees, Subscriptions & Promotions			17,957	17,957	17,957	(1,940)	16,017			20
21	Clerical & General Office Expenses			14,753	14,753	14,753	1,607	16,360			21
22	Employee Benefits & Payroll Taxes			568,909	568,909	568,909	20,549	589,458			22
23	Inservice Training & Education						453	453			23
24	Travel and Seminar			977	977	977	547	1,524			24
25	Other Admin. Staff Transportation			4,056	4,056	4,056		4,056			25
26	Insurance-Prop.Liab.Malpractice						17,669	17,669			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	276,897	16,207	772,740	1,065,844	1,065,844	18,401	1,084,245			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,868,797	371,181	1,929,830	4,169,808	4,169,808	14,074	4,183,882			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.

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			315,958	315,958	315,958	(743)	315,215				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						2,398	2,398				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						8,950	8,950				34
35	Rent-Equipment & Vehicles			4,523	4,523	4,523	308	4,831				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			320,481	320,481	320,481	10,913	331,394				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			184,496	184,496	184,496		184,496				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			158,602	158,602	158,602		158,602				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			343,098	343,098	343,098		343,098				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,868,797	371,181	2,593,409	4,833,387	4,833,387	24,987	4,858,374				45

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

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<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	(8,063)	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	(2,375)	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	(2,147)	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>	\$ (12,585)		\$	30

**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>	\$ (12,585)		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

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

A MERKLE C KNIPPRATH N H

ID# 0021832

Report Period Beginning: 1/01/15

Ending: 12/31/15

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

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
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20				20
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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:

1/01/15

Ending:

12/31/15

## 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	(8,063)	588	0	0	0	0	0	0	0	0	0	(7,475)	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	905	0	0	0	0	0	0	0	0	0	905	5
6	Maintenance	0	1,439	588	0	0	0	0	0	0	0	0	2,027	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,063)</b>	<b>2,932</b>	<b>588</b>	<b>0</b>	<b>(4,543)</b>	<b>8</b>							
	<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	216	0	0	0	0	0	0	0	0	0	216	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>	<b>0</b>	<b>216</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>216</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(44,575)	7,833	0	0	0	0	0	0	0	0	(36,742)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,258	0	0	0	0	0	0	0	0	0	16,258	19
20	Fees, Subscriptions & Promotions	(2,147)	207	0	0	0	0	0	0	0	0	0	(1,940)	20
21	Clerical & General Office Expenses	0	1,607	0	0	0	0	0	0	0	0	0	1,607	21
22	Employee Benefits & Payroll Taxes	0	18,873	1,676	0	0	0	0	0	0	0	0	20,549	22
23	Inservice Training & Education	0	453	0	0	0	0	0	0	0	0	0	453	23
24	Travel and Seminar	0	547	0	0	0	0	0	0	0	0	0	547	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	17,669	0	0	0	0	0	0	0	0	0	17,669	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(2,147)</b>	<b>11,039</b>	<b>9,509</b>	<b>0</b>	<b>18,401</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(10,210)</b>	<b>14,187</b>	<b>10,097</b>	<b>0</b>	<b>14,074</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

1/01/15

Ending:

12/31/15

## 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	(2,375)	0	1,632	0	0	0	0	0	0	0	0	(743)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2,398	0	0	0	0	0	0	0	0	2,398	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	8,950	0	0	0	0	0	0	0	0	8,950	34
35	Rent-Equipment & Vehicles	0	0	308	0	0	0	0	0	0	0	0	308	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,375)</b>	<b>0</b>	<b>13,288</b>	<b>0</b>	<b>10,913</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)	(12,585)	14,187	23,385	0	0	0	0	0	0	0	0	24,987	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	Chicago	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	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)		
1	V	2 Food	\$	Presence Life Connections	100.00%	\$ 588	\$	588	1
2	V	5 Utilities		Presence Life Connections	100.00%	905		905	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	1,439		1,439	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	216		216	4
5	V	17 Admin - Misc. Other	144,167	Presence Life Connections	100.00%	5,429		(138,738)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	94,163		94,163	6
7	V	19 Professional Services		Presence Life Connections	100.00%	16,258		16,258	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	207		207	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	1,607		1,607	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	18,873		18,873	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	453		453	11
12	V	24 Travel		Presence Life Connections	100.00%	547		547	12
13	V	26 Insurance		Presence Life Connections	100.00%	17,669		17,669	13
14	Total		\$ 144,167			\$ 158,354	\$ *	14,187	14

\* 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%	\$ 1,691	\$	1,691	15
16	V	32 Interest		Presence Life Connections	100.00%	0			16
17	V	34 Rent - Facility		Presence Life Connections	100.00%	8,459		8,459	17
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	308		308	18
19	V	17 Admin Salaries		Presence Health	100.00%	2,764		2,764	19
20	V	22 Employee Benefits		Presence Health	100.00%	1,676		1,676	20
21	V	30 Depreciation	118	Presence Health	100.00%	59		(59)	21
22	V	34 Rent Facility		Presence Health	100.00%	491		491	22
23	V	17 Admin Consulting,Other	12,011	Presence Health	100.00%	10,196		(1,815)	23
24	V	17 Information Systems Salaries		Presence Health	100.00%	980		980	24
25	V	17 Information Systems - Other		Presence Health	100.00%	3,501		3,501	25
26	V	17 Admin Salaries		Presence Health	100.00%	810		810	26
27	V	17 Information Systems Salaries		Presence Health	100.00%	1,117		1,117	27
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%	588		588	28
29	V	17 Admin Consulting,Other		Presence Health	100.00%	476		476	29
30	V	32 Admin - Interest Expense		Presence Health	100.00%	2,398		2,398	30
31	V	39 Ancillary Services - Other	184,496	Presence Senior Services Pharmacy	100.00%	184,496			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 196,625			\$ 220,010	\$ *	23,385	39

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

Facility Name & ID Number

A MERKLE C KNIPPRATH N H

# 0021832

Report Period Beginning:

1/01/15

Ending:

12/31/15

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 1/01/15 Ending: 12/31/15

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	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NA							\$		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:

1/01/15

Ending: 12/31/15

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	7,761,581	27	\$ 31,634	\$ 144,167	\$ 588	1	
2	5	Utilities	Management Fee Income	7,761,581	27	48,706	144,167	905	2	
3	6	Maintenance - Other	Management Fee Income	7,761,581	27	77,498	144,167	1,439	3	
4	11	Activities-Special Events	Management Fee Income	7,761,581	27	11,644	144,167	216	4	
5	17	Admin - Misc. Other	Management Fee Income	7,761,581	27	292,301	144,167	5,429	5	
6	17	Administrative Salaries	Management Fee Income	7,761,581	27	5,069,517	5,069,517	144,167	94,163	6
7	19	Professional Services	Management Fee Income	7,761,581	27	875,274	144,167	16,258	7	
8	20	Dues,Subscriptions	Management Fee Income	7,761,581	27	11,166	144,167	207	8	
9	21	Clerical Supplies	Management Fee Income	7,761,581	27	86,492	144,167	1,607	9	
10	22	Employee Benefits	Management Fee Income	7,761,581	27	1,016,065	144,167	18,873	10	
11	23	Education/Conference	Management Fee Income	7,761,581	27	24,366	144,167	453	11	
12	24	Travel	Management Fee Income	7,761,581	27	29,466	144,167	547	12	
13	26	Insurance	Management Fee Income	7,761,581	27	951,237	144,167	17,669	13	
14	30	Depreciation	Management Fee Income	7,761,581	27	91,051	144,167	1,691	14	
15	32	Interest	Management Fee Income	7,761,581	27	0	144,167	0	15	
16	34	Rent - Facility	Management Fee Income	7,761,581	27	455,407	144,167	8,459	16	
17	35	Rent - Equipment	Management Fee Income	7,761,581	27	16,606	144,167	308	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 9,088,430	\$ 5,069,517	\$ 168,812	25	

Facility Name & ID Number A MERKLE C KNIPPRATH N H

# 0021832

Report Period Beginning:

1/01/15

Ending: 12/31/15

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	5,977,354	17	\$ 1,375,283	\$ 1,375,283	12,011	\$ 2,764	1
2	22	Employee Benefits	Operating Expense	5,977,354	17	834,149		12,011	1,676	2
3	30	Depreciation	Operating Expense	1,607,196	17	803,889		118	59	3
4	34	Rent Facility	Operating Expense	5,977,354	17	244,378		12,011	491	4
5	17	Admin Consulting,Other	Operating Expense	5,977,354	17	5,074,164		12,011	10,196	5
6	17	Information Systems Salaries	Operating Expense	5,977,354	17	487,675	487,675	12,011	980	6
7	17	Information Systems - Other	Operating Expense	5,977,354	17	1,742,443		12,011	3,501	7
8	17	Admin Salaries	Direct Cost	5,977,354	17	403,064	403,064	12,011	810	8
9	17	Information Systems Salaries	Direct Cost	5,977,354	17	555,758	555,758	12,011	1,117	9
10	6	Information Systems - Equip Mai	Direct Cost	5,977,354	17	292,852		12,011	588	10
11	17	Admin Consulting,Other	Direct Cost	5,977,354	17	237,106		12,011	476	11
12	32	Admin - Interest Expense	Direct Cost	5,977,354	17	1,193,207		12,011	2,398	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		\$ 25,056	25

Facility Name & ID Number A MERKLE C KNIPPRATH N H

# 0021832

Report Period Beginning:

1/01/15

Ending: 12/31/15

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 Omnicare of Peoria  
 Street Address 2305 W. Altorfer Dr.  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309-691-2010  
 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	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 184,496	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				\$	\$		\$ 184,496	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 2014 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 2015 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:	2010	_____	8	<b>FOR BHF USE ONLY</b>		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2014 \$	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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME A. MERKLE C KNIPPRATH NURSING HOME 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 2014 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 2014.

	(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>	\$ _____	\$ _____

**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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

Empty lines for listing other business entities.

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

Table with 6 columns: Use, Square Feet, Year Acquired, Cost, and two unlabeled columns. Rows include NURSING HOME, FARM/ILU, and TOTALS.

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	\$ 9,663	40	\$ 9,663	\$	\$ 773,036
5	15	2013	1992	1,465,015	41,279	30	41,279		990,489
6									
7									
8									
Improvement Type**									
9	VARIOUS		1986	324,830	7,934	40	7,934		244,829
10	VARIOUS		1995	177,260	6,363	24	6,363		132,268
11	VARIOUS		1998	7,339	367	20	367		6,406
12	VARIOUS		2000	53,780	2,216	20	2,216		34,273
13	VARIOUS		2001	12,094	806	15	806		11,727
14	VARIOUS		2002	69,025	3,124	21	3,124		42,149
15	VARIOUS		2003	52,773	2,639	20	2,639		32,977
16	VARIOUS		2004	54,894	4,978	13	4,978		51,067
17	VARIOUS		2005	3,058	230	13	230		2,378
18	VARIOUS		2006	12,830	855	15	855		8,123
19	VARIOUS		2007	18,065	1,271	17	1,271		11,429
20	VARIOUS		2008	141,675	19,860	14	9,860	(10,000)	75,488
21	VARIOUS		2009	87,276	5,019	16	5,019		32,620
22									
23	FLOORING NURSING CHART ROOM		2012	3,155	316	10	316		1,104
24									
25	8 PTAC AC UNITS INSULATED WALL		2014	7,124	712	10	712		1,071
26	ELECTRICAL PROBLEMS WITH AC UN		2014	3,826	383	10	383		572
27	FURNACE FOR EAST HALLWAY		2014	2,613	174	15	174		262
28	MATERIAL LABOR ENTRY HALL DINI		2014	262,443	17,496	15	17,496		26,388
29	PAINTING TO 6 UNITS AND COMMON		2014	4,000	800	5	800		1,194
30	THERAPY ACTIVITY ROOM FLOORING		2014	14,636	976	15	976		1,462
31	THERAPY ROOM PTAC UNITS		2014	3,495	349	10	349		522
32	WIRELESS INTERNET		2014	73,173	7,317	10	7,317		17,366
33									
34									
35									
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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	ARTWORK	2015	\$ 7,451	\$ 710	7	\$ 1,064	\$ 355	\$ 710	37
38	BEDS AND SURFACES	2015	25,321	938	18	1,407	469	938	38
39	BEDSIDE TABLES	2015	5,074	148	20	254	106	148	39
40	BLANKET WARMER	2015	3,695	164	15	246	82	164	40
41	D.W. PAYNE 2 TON 13 SEER AC UN	2015	3,100	26	20	155	129	26	41
42	DISHWASHER	2015	3,400	189	12	283	94	189	42
43	ELECTRICAL RE WIRING IN PRIVATE THERAPY SUITE	2015	33,271	1,525	20	1,664	139	1,525	43
44	GAS FURNACE	2015	3,400	337	15	227	(111)	337	44
45	HVAC UPGRADES	2015	24,890	1,245	15	1,659	415	1,245	45
46	LABOR FOR INSTALLATION OF LIGH	2015	12,788	1,269	15	853	(416)	1,269	46
47	LIGHTING AND FIXTURES	2015	11,268	1,104	15	751	(353)	1,104	47
48	NURSE STATION REMODEL	2015	27,146	339	20	1,357	1,018	339	48
49	PATIENT TRANSPORTATION SLINGS	2015	16,628	1,240	20	831	(409)	1,240	49
50	PHONES	2015	21,515	1,972	10	2,151	179	1,972	50
51	INSTALL NEW WINDOWS/CARPET IN PVT THERAPY SUITE	2015	40,389	1,851	20	2,019	168	1,851	51
52	PTAC A C UNIT	2015	73,265	9,314	10	7,327	(1,988)	9,314	52
53	CONSTRUCTION OF 14 PVT THRPY RMS IN ARTHUR HALL	2015	143,565	6,580	20	7,178	598	6,580	53
54	NEW PAINT/FLOORING/SINKS IN RESIDENT ROOMS	2015	99,094	413	20	4,955	4,542	413	54
55	RESIDENT ROOM RENOVATIONS CEIL	2015	96,479	1,407	40	2,412	1,005	1,407	55
56	ROOFING AND RELATED WORK	2015	415,700	25,124	20	20,785	(4,339)	25,124	56
57	TELEVISIONS AND MOUNTING BRACK	2015	15,584	1,039	5	3,117	2,078	1,039	57
58	TUCKPOINTING MASONRY	2015	26,235	700	25	1,049	350	700	58
59	WINDOW TREATMENTS	2015	4,655	388	5	931	543	388	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)		\$ 4,741,326	\$ 193,149		\$ 187,803	\$ (5,346)	\$ 2,557,221	70

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

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	\$ 1,188,199	\$ 119,149	\$ 119,149	\$	11	\$ 888,336	71
72	Current Year Purchases	59,989	3,543	6,513	2,971	10	3,543	72
73	Fully Depreciated Assets	250,490				16	250,490	73
74	Home Office Allocation		118	118				74
75	TOTALS	\$ 1,498,678	\$ 122,809	\$ 125,780	\$ 2,971		\$ 1,142,369	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,297,005	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 315,958	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 313,583	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,375)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,699,590	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	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H

# 0021832

Report Period Beginning: 1/01/15

Ending: 12/31/15

**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				8,950			5
6								6
7	TOTAL				\$ 8,950			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. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

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

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

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

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 4,831

Description: Administration 2343, Nursing 2180, Home Office

(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 A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 1/01/15 Ending: 12/31/15  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
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**

<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	1668	hrs	\$ 41,689	3,947	\$ 237,005	\$	5,615	\$ 278,694	1
2	Licensed Speech and Language Development Therapist	10a,3		hrs		295	18,783		295	18,783	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a,3	1943	hrs	63,470	4,267	259,190		6,210	322,660	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				184,496		184,496	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>				\$ 105,159	8,509	\$ 514,978	\$ 184,496	12,120	\$ 804,633	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: **1/01/15**

Ending:

**12/31/15****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/15** (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	\$ 15,116,271	\$	1
2	Cash-Patient Deposits	142,276		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	38,985,402		3
4	Supply Inventory (priced at )	1,405,559		4
5	Short-Term Investments	1,530,325		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,822,954		7
8	Accounts Receivable (owners or related parties)	2,119,287		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 61,122,074	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,185,056		12
13	Land	17,252,477		13
14	Buildings, at Historical Cost	235,676,159		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	69,751,494		16
17	Accumulated Depreciation (book methods)	(179,552,982)		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):	397,300		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 156,709,504	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 217,831,578	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 13,801,729	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,484,204		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	3,400		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,921,984		32
33	Accrued Interest Payable	6,273		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Third Parties</u>	(1,674,742)		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 40,542,848	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,286,073		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>	99,654		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,385,727	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 41,928,575	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 175,903,003	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 217,831,578	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,167,735	1
2	Restatements (describe):		2
3			3
4	Adj to reconcile consolidated equity & consolidated income	102,531,209	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 175,698,944	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(262,393)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,437,836	11
12	Expenditures for Specific Purposes	(971,384)	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)	\$ 204,059	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)	\$ 175,903,003	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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,102,156	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,102,156	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,279,249	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,279,249	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		13
14	Non-Patient Meals	8,063	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	165,940	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>	\$ 174,003	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	13,917	24
25	Interest and Other Investment Income***	1,669	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 15,586	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,570,994	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,024,835	31
32	Health Care	2,079,129	32
33	General Administration	1,065,844	33
<b>B. Capital Expense</b>			
34	Ownership	320,481	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	184,496	35
36	Provider Participation Fee	158,602	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,833,387	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(262,393)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (262,393)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,273,058	44
45	Private Pay - Net Inpatient Revenue	1,199,979	45
46	Medicare - Net Inpatient Revenue	595,607	46
47	Other-(specify) <u>Insurance</u>	33,512	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,102,156	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:

1/01/15

Ending:

12/31/15

**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	1,867	2,153	\$ 77,170	\$ 35.84	1
2	Assistant Director of Nursing	1,601	1,775	47,886	26.98	2
3	Registered Nurses	10,284	11,154	285,904	25.63	3
4	Licensed Practical Nurses	13,800	14,810	274,390	18.53	4
5	CNAs & Orderlies	44,276	47,760	478,237	10.01	5
6	CNA Trainees					6
7	Licensed Therapist	3,883	3,916	105,159	26.85	7
8	Rehab/Therapy Aides	3,234	3,521	28,833	8.19	8
9	Activity Director	1,886	2,087	31,725	15.20	9
10	Activity Assistants	5,165	5,515	60,005	10.88	10
11	Social Service Workers	1,215	1,330	20,049	15.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	12,176	13,071	175,784	13.45	17
18	Housekeepers	-				18
19	Laundry					19
20	Administrator	1,930	2,088	94,887	45.44	20
21	Assistant Administrator					21
22	Other Administrative	-				22
23	Office Manager	1,425	1,540	26,117	16.96	23
24	Clerical	7,934	8,441	98,030	11.61	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	1,934	2,018	38,777	19.22	32
33	Other(specify) Pastoral	973	999	25,845	25.87	33
34	TOTAL (lines 1 - 33)	113,583	122,178	\$ 1,868,798 *	\$ 15.30	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly 12,000	9,3	36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	\$6.40/resident	4,122	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	12	1,086	11,2	44
45	Social Service Consultant	12	1,086	12,2	45
46	Other(specify)			46	
47				47	
48				48	
49	TOTAL (lines 35 - 48)	24	\$ 18,294	49	

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	74	\$ 4,497	10,2	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	55	1,339	10,2	52
53	TOTAL (lines 50 - 52)	129	\$ 5,836	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:

1/01/15

Ending:

12/31/15

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. LEADING AGE \$3264.04
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,712 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. \$ 158,602  
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. \$ 8,063
- (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.