

Facility Name & ID Number Knox County Nursing Home

0010561 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

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 N/A

	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	169	Skilled (SNF)	169	61,685	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	169	TOTALS	169	61,685	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			2,794	2,794	8
9	SNF/PED					9
10	ICF	27,383	18,952		46,335	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,383	18,952	2,794	49,129	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.64%

D. How many bed-hold days during this year were paid by the Department? None (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)
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 8/28/1966

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 169 and days of care provided 2,114

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30 Fiscal Year: 11/30

* 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
	A. General Services										
1	Dietary	430,578	29,167	9,773	469,518		469,518		469,518		1
2	Food Purchase		314,122		314,122		314,122	(16,556)	297,566		2
3	Housekeeping	258,648	35,569		294,217		294,217		294,217		3
4	Laundry	74,046	20,563	106,722	201,331		201,331		201,331		4
5	Heat and Other Utilities			220,992	220,992		220,992		220,992		5
6	Maintenance	135,084	2,985	137,861	275,930		275,930	(40,523)	235,407		6
7	Other (specify):*										7
8	TOTAL General Services	898,356	402,406	475,348	1,776,110		1,776,110	(57,079)	1,719,031		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	4,048,532	210,820	9,959	4,269,311		4,269,311		4,269,311		10
10a	Therapy		733		733		733		733		10a
11	Activities	101,356	4,035		105,391		105,391		105,391		11
12	Social Services	100,076	567		100,643		100,643		100,643		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,249,964	216,155	18,959	4,485,078		4,485,078		4,485,078		16
	C. General Administration										
17	Administrative	72,566			72,566		72,566		72,566		17
18	Directors Fees										18
19	Professional Services			51,431	51,431		51,431		51,431		19
20	Dues, Fees, Subscriptions & Promotions			42,013	42,013		42,013	(10,978)	31,035		20
21	Clerical & General Office Expenses	210,698	13,769	119,843	344,310		344,310	(107,130)	237,180		21
22	Employee Benefits & Payroll Taxes			1,249,106	1,249,106		1,249,106	415,154	1,664,260		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,629	14,629		14,629	(826)	13,803		24
25	Other Admin. Staff Transportation			2,290	2,290		2,290		2,290		25
26	Insurance-Prop.Liab.Malpractice			49,766	49,766		49,766		49,766		26
27	Other (specify):*										27
28	TOTAL General Administration	283,264	13,769	1,529,078	1,826,111		1,826,111	296,220	2,122,331		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,431,584	632,330	2,023,385	8,087,299		8,087,299	239,141	8,326,440		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Knox County Nursing Home

#0010561

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			279,381	279,381		279,381		279,381			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			7,643	7,643		7,643		7,643			35
36	Other (specify):*											36
37	TOTAL Ownership			287,024	287,024		287,024		287,024			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,319	526,509	631,828		631,828		631,828			39
40	Barber and Beauty Shops	26,808	1,326		28,134		28,134	(6,160)	21,974			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			402,104	402,104		402,104		402,104			42
43	Other (specify):*			1,322	1,322		1,322	(1,322)				43
44	TOTAL Special Cost Centers	26,808	106,645	929,935	1,063,388		1,063,388	(7,482)	1,055,906			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,458,392	738,975	3,240,344	9,437,711		9,437,711	231,659	9,669,370			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 Knox County Nursing Home

0010561

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(16,556)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,547)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(100,574)	21		24
25	Fund Raising, Advertising and Promotional	(10,978)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(48,840)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (183,495)		\$	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	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (183,495)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Knox County Nursing Home

ID# 0010561

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Barber & Beauty Revenue Offset	\$ (6,160)	40	1
2	Bank Charges	(9)	21	2
3	County Farm Taxes	(1,322)	43	3
4	Duplicated Seminar/Travel	(826)	24	4
5	Capitalized R&M	(40,523)	6	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(48,840)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nursing Home# 0010561

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(16,556)	0	0	0	0	0	0	0	0	0	0	(16,556)	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	(40,523)	0	0	0	0	0	0	0	0	0	0	(40,523)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(57,079)	0	0	0	0	0	0	0	0	0	0	(57,079)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(10,978)	0	0	0	0	0	0	0	0	0	0	(10,978)	20
21	Clerical & General Office Expenses	(107,130)	0	0	0	0	0	0	0	0	0	0	(107,130)	21
22	Employee Benefits & Payroll Taxes	0	415,154	0	0	0	0	0	0	0	0	0	415,154	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(826)	0	0	0	0	0	0	0	0	0	0	(826)	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	TOTAL General Administration	(118,934)	415,154	0	296,220	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(176,013)	415,154	0	239,141	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/1/2014 Ending:

11/30/2015

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)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	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	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(6,160)	0	0	0	0	0	0	0	0	0	0	(6,160)	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):*	(1,322)	0	0	0	0	0	0	0	0	0	0	(1,322)	43
44	TOTAL Special Cost Centers	(7,482)	0	0	0	0	0	0	0	0	0	0	(7,482)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(183,495)	415,154	0	231,659	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
<u>Knox County</u>	<u>100%</u>			<u>None</u>		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>19 Portion of IT Support</u>	\$ <u>27,539</u>	<u>Knox County</u>	<u>100.00%</u>	\$ <u>27,539</u>	\$	<u>1</u>
2	V	<u>22 IMRF- County</u>		<u>Knox County</u>	<u>100.00%</u>	<u>228,335</u>		<u>228,335</u>
3	V	<u>22 Payroll Taxes - County</u>		<u>Knox County</u>	<u>100.00%</u>	<u>186,819</u>		<u>186,819</u>
4	V							
5	V							
6	V							
7	V							
8	V							
9	V							
10	V							
11	V							
12	V							
13	V							
14	Total		\$ <u>27,539</u>			\$ <u>442,693</u>	\$ *	<u>415,154</u>

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

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	Richard Conklin	BOD						1
2	Cheryl Nache	BOD						2
3	Lyle Johnson	BOD						3
4	Greg Bacon	BOD						4
5	John Hunigan	BOD						5
6	Robert Bondi	BOD						6
7	Barbara Foster	BOD						7
8	Pamela Davidson	BOD						8
9	Trisha Hurst	BOD						9
10	George L. Knapp	BOD						10
11	Shawn Pitman	BOD						11
12	David Erickson	BOD						12
13	Jeff Jefferson	BOD						13
14	Ricardo D. Sandoval	BOD						14
15	Brian Friedrich	BOD						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

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	County Board Members		Committee	0.00	None	Various		Per-Diem/	\$	1
2								Mileage	2,290	25-03
3										3
4										4
5										5
6										6
7										7
8	Knox County holds committee meetings related to the nursing home.									
9	Per-deims and mileage are paid separately by the nursing home.									
10										10
11										11
12										12
13								TOTAL	\$ 2,290	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 Knox County Nursing Home

0010561 Report Period Beginning: 12/1/2014

Ending: 1/30/2015

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 Knox County
 Street Address 200 South Sherry Street
 City / State / Zip Code Galesburg, IL 61401
 Phone Number (309) 343-3121
 Fax Number (309) 343-7002

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	19	Portion of IT Support	Direct Cost	169	\$ 27,539	\$	169	\$ 27,539	1
2	22	IMRF- County	Direct Cost	169	228,335		169	228,335	2
3	22	Payroll - County	Direct Cost	169	186,819		169	186,819	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				\$ 442,693	\$		\$ 442,693	25

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																					
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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																		
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																																		
Real Estate Tax History:																																					
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2010</td><td>_____</td><td>8</td></tr> <tr><td>2011</td><td>_____</td><td>9</td></tr> <tr><td>2012</td><td>_____</td><td>10</td></tr> <tr><td>2013</td><td>_____</td><td>11</td></tr> <tr><td>2014</td><td>_____</td><td>12</td></tr> </table>	2010	_____	8	2011	_____	9	2012	_____	10	2013	_____	11	2014	_____	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2014</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>		FOR BHF USE ONLY			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
2010	_____	8																																			
2011	_____	9																																			
2012	_____	10																																			
2013	_____	11																																			
2014	_____	12																																			
FOR BHF USE ONLY																																					
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																																		
Facility is exempt from paying real estate taxes.																																					

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 Knox County Nursing Home COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0010561

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 374-0400 FAX #: (847) 374-0420

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.	N/A		\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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: 100,375 B. General Construction Type: Exterior Brick Frame Steel 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).

None

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>Facility</u>	<u>1,481,040</u>	<u>1966</u>	<u>\$ 156,600</u>	1
2					2
3	TOTALS	1,481,040		\$ 156,600	3

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	169		1966	1966	\$ 1,842,192	\$	50	\$ 36,844	\$ 36,844	\$ 1,824,644	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1966		46,724		20	934	934	43,329	9
10	Various		1971		146,065		20			146,065	10
11	Various		1980		9,972		20			9,972	11
12	Various		1981		650		20			650	12
13	Various		1983		14,762		20			14,762	13
14	Various		1984		31,009		20			31,009	14
15	Various		1985		73,090		20			73,090	15
16	Various		1986		141,506		20			141,506	16
17	Various		1987		142,693		20			142,693	17
18	Various		1988		60,820		20			60,820	18
19	Various		1989		47,469		20			47,469	19
20	Various		1990		29,117		20			29,117	20
21	Various		1991		17,547		20			17,547	21
22	Various		1992		197,932		20			197,932	22
23	Various		1993		97,234		20	5,812	5,812	97,234	23
24	Various		1994		45,232		20			45,232	24
25	Various		1995		58,215		20			58,215	25
26	Various		1996		76,390		20			76,390	26
27	Various		1997		26,377		20			26,377	27
28	Various		1998		39,334		20	1,676	1,676	35,162	28
29	Various		1999		21,237		20	416	416	21,237	29
30	Various		2000		20,496		20			20,496	30
31	Various		2001		1,395		20			1,395	31
32	Various		2003		161,240		20	8,448	8,448	88,897	32
33	Various		2004		116,328		20	6,827	6,827	63,471	33
34	Various		2005		327,652		20	16,383	16,383	146,790	34
35	Various		2006		1,002,155		20	49,800	49,800	399,322	35
36	Various		2007		480,150		20	4,856		33,993	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/1/2014

Ending:

11/30/2015

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	Various	2008	\$ 396,911	\$	20	\$ 7,473	\$ 7,473	\$ 52,316	37
38	Various	2009	386,135		20	12,487	12,487	86,188	38
39	Various	2010	34,807		20	1,758	1,758	9,840	39
40	Various	2011	1,483,738		20	74,187	74,187	99,231	40
41	Land Improvements	2012	4,999		20	250	250	917	41
42	Garbage Disposer	2012	2,318		20	116	116	648	42
43	Door Replacement	2012	4,245		20	212	212	764	43
44	Boiler Replacement	2012	161,125		20	8,056	8,056	19,644	44
45	Door Locks & Keypads	2012	3,329		20	166	166	809	45
46	Smoke Dampers	2012	8,458		20	423	423	2,104	46
47	Sidewalk Replacement	2013	4,900		20	245	245	572	47
48	Additional Boiler Project	2013	17,876		20	894	894	2,086	48
49	Gazebo Roof	2013	4,800		20	240	240	540	49
50	Ice Machine - (Plumbing Roughed-In)	2013	4,687		20	234	234	507	50
51	Garage Roof	2013	3,500		20	175	175	379	51
52	Flooring Office/Reception	2013	4,353		20	218	218	671	52
53	Parking Lot Rehab (Repairs, Sealcoating, remarking)	2014	58,684		20	2,934	2,934	3,912	53
54	Room 405 (Plumbing, Carpet, And Walls)	2014	20,438		20	1,022	1,022	1,618	54
55	Light Pole in Parking Lot	2014	5,013		20	251	251	397	55
56	Wing 2 Faucet Replacement	2014	4,456		20	223	223	353	56
57	Wing 4 Fire Door	2014	2,624		20	131	131	142	57
58	Sidewalk Replacement	2014	4,500		20	225	225	281	58
59	Kitchen Renovation (Flooring , Plumbing, Drywall, Lighting)	2014	84,258		20	4,213	4,213	4,564	59
60	Wings 1,2,3,4 Heating Units Replacement	2014	4,847		20	242	242	464	60
61	Wings 1,2,3,4 Heating Units Replacement	2014	20,138		20	1,007	1,007	2,014	61
62	Fire Door - Wing 4	2014	2,624		20	131	131	131	62
63	Kitchen Remodel - Feed for Mobil Kitchen	2015	3,378		20	99	99	99	63
64	Replace Relief Valve/Steam Header/Traps - Boiler	2015	27,342		20	1,253	1,253	1,253	64
65	Plumbing Boiler Room	2015	3,773		20	31	31	31	65
66	Hot Water Piping	2015	3,406		20	14	14	14	66
67									67
68									68
69	Book Depreciation			279,381			(279,381)		69
70	TOTAL (lines 4 thru 69)		\$ 8,046,644	\$ 279,381		\$ 250,906	\$ (33,331)	\$ 4,187,305	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	\$ 1,871,669	\$	\$ 49,379	\$ 49,379		\$ 1,365,309	71
72	Current Year Purchases	5,858		439	439		439	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,877,527	\$	\$ 49,818	\$ 49,818		\$ 1,365,748	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		Ford Escort	1993	\$ 10,827	\$	\$	\$		\$ 10,827	76
77		Ford Truck	1995	17,024					17,024	77
78		Van	2005	78,436					78,436	78
79		Tuck Overhaul	2014	2,882		576	576		768	79
80	TOTALS			\$ 109,169	\$	\$ 576	\$ 576		\$ 107,055	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)	\$ 10,189,940	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 279,381	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 301,301	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,920	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,660,108	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 Knox County Nursing Home

0010561

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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: \$ 7,643 Description: Postage Meter - \$639, Copy Machine - \$6,872, Construction Lift - \$132

(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 Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2014 Ending: 11/30/2015
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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		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	39+3	hrs	\$		\$	192,834	\$		\$	192,834	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				106,463				106,463	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39-3	hrs				226,465				226,465	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescripts					89,214			89,214	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <u>Oxygen/Supplies</u>							16,105			16,105	12
13	Other (specify): <u>Lab Services</u>							1,747			1,747	13
14	TOTAL			\$		\$	527,509	\$	105,319	\$	632,828	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 Knox County Nursing Home# 0010561Report Period Beginning: 12/1/2014Ending: 11/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 948,038	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (109,423))	1,557,831		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Property Tax Rec.</u>	755,896		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,261,765	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,004,890		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	9,148,706		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(6,133,587)		17
18	Deferred Charges	843,867		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,863,876	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,125,641	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 184,129	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	736,058		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Others</u>	25,817		36
37	<u>Deferred Property Taxes</u>	745,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,691,004	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,691,004	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,434,637	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,125,641	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,346,932	1
2	Restatements (describe):		2
3	IMRF - Audit Adjustment	221,487	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,568,419	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(133,782)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (133,782)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,434,637	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		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 8,186,640	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,186,640	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	129,079	6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 129,079	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop	3,744	12	
13	Barber and Beauty Care	6,160	13	
14	Non-Patient Meals	12,812	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs		17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services	22,224	21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 44,940	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	84,506	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 84,506	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28			28	
28a	<u>See Attached</u>	858,764	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 858,764	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,303,929	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,776,110	31	
32	Health Care	4,485,078	32	
33	General Administration	1,826,111	33	
B. Capital Expense				
34	Ownership	287,024	34	
C. Ancillary Expense				
35	Special Cost Centers	661,284	35	
36	Provider Participation Fee	402,104	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,437,711	40	
41	Income before Income Taxes (line 30 minus line 40)**	(133,782)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (133,782)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,775,828	44
45	Private Pay - Net Inpatient Revenue	2,391,973	45
46	Medicare - Net Inpatient Revenue	809,791	46
47	Other-(specify) <u>Insurance</u>	1,876,794	47
48	Other-(specify) <u>Hospice</u>	332,254	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,186,640	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.

	Other Current Assets:	<u>Amount</u>
28A	TRANS IN-TORT STOP LOSS	(107,783.00)
	TRANS IN -REFERENDUM	(500,000.00)
	Cap. Improv. Transfer	(5,858.00)
	FARM INCOME	(16,137.00)
	TRANS TO OTHER FUNDS	500,000.00
	CURRENT PROPERTY TAX	(731,910.00)
	UNANTICIPATED REVENUE	(2,934.00)
	Transfer to NH Fund	5,858.00
	TRANS TO OTHER FUNDS	
		<u>(858,764.00)</u>

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

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	2,097	2,311	\$ 99,473	\$ 43.04	1
2	Assistant Director of Nursing	2,097	2,311	61,223	26.49	2
3	Registered Nurses	20,974	23,113	500,568	21.66	3
4	Licensed Practical Nurses	57,345	63,192	982,582	15.55	4
5	CNAs & Orderlies	177,176	197,081	2,404,686	12.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,612	1,748	39,326	22.50	9
10	Activity Assistants	7,265	7,877	62,030	7.87	10
11	Social Service Workers	7,539	8,519	100,076	11.75	11
12	Dietician					12
13	Food Service Supervisor	3,791	4,139	58,446	14.12	13
14	Head Cook	33,362	36,421	372,132	10.22	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	8,344	9,421	135,084	14.34	17
18	Housekeepers	22,075	24,890	258,648	10.39	18
19	Laundry	6,547	7,337	74,046	10.09	19
20	Administrator	2,080	2,282	72,566	31.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,687	14,765	210,698	14.27	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 Care(specify)					32
33	Other(specify) <u>Barber & Beauty</u>	1,710	1,826	26,808	14.68	33
34	TOTAL (lines 1 - 33)	367,701	407,233	\$ 5,458,392 *	\$ 13.40	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	244	\$ 9,773	1-3	35
36	Medical Director	Monthly	9,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	11	447	10-3	38
39	Pharmacist Consultant	Monthly	9,512	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	255	\$ 28,732		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Rachel Secrist	Administrator	0	\$ 72,566	Workers' Compensation Insurance	\$ 197,541	IDPH License Fee	\$	
				Unemployment Compensation Insurance	41,785	Advertising: Employee Recruitment	348	
				FICA Taxes	407,639	Health Care Worker Background Check		
				Employee Health Insurance	898,437	(Indicate # of checks performed <u>51</u>)	988	
				Employee Meals		Patient Background Checks	115 1,776	
				Illinois Municipal Retirement Fund (IMRF)*	507,515	Dues & Subscriptions	1,453	
				Trans In-SS	(186,819)	Pre-Employment Testing	26,470	
				Trans In - IMRF	(228,335)	Marketing Srevices	10,978	
				IMRF-NPO	(388,657)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 72,566			Less: Public Relations Expense	(10,978)	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
David & Cambell	Legal		\$ 2,141			\$	Out-of-State Travel	\$
Duane Morris	Legal		6,724					
Wipfli	Audit		600					
FGMK, LLC	Healthcare Consulting		9,375				In-State Travel	8,246
Miller Dredge	Surety Bond		1,072					
CGS Administrators	Data Processing		3,980					
Knox County	Reimbursed IT		27,539				Seminar Expense	5,557
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 51,431	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 13,803

* Attach copy of IMRF notifications

**See instructions.

Knox County Nursing Home
0052589
Legal Schedule
12/1/2014-11/30/2015

<u>Date</u>	<u>Vendor</u>	<u>Description</u>	<u>Amount</u>	<u>ADJ</u>	<u>Allowable</u>
3/25/2015	Davis & Campbell	KJB	1227.5		1227.5
6/24/2015	Davis & Campbell	Matter 008	493		493
6/24/2015	Davis & Campbell	Matter 019	72.5		72.5
7/22/2015	Duane Morris	Managed Care Cons.	7599		7599
8/26/2015	Duane Morris	Managed Care Cons.	4124.5		4124.5
11/15/2015	Davis & Campbell	Matter 008	348		348
		Total	13,865	-	13,865

Knox County Nursing Home
0052589
Seminar Schedule
12/1/2014-11/30/2015

Date	Payee	Topic	Attendee	Job Description	City/State	Amount	Adjusted	Allowable
12/29/2014	Classic Accents	New Employee Tags	All Staff		In House	67		67
12/29/2014	Staples	Training	Adm. Ass.	HR	In House	140		140
1/28/2015	Deb Inman	Clinical Training	Nursing Staff	Training	In House	240		240
1/28/2015	Staples	Training	Cathy Bowton	HR	In House	73		73
1/28/2015	Elan	Conference	4 County Employees	INHAA	Springfield	77		77
1/28/2015	Classic Accents	Name Tags	All Staff		In House	50		50
2/25/2015	Classic Accents	Name Tags	All Staff		In House	39		39
2/25/2015	Deb Inman	Clinical Training	Nursing Staff	Training	In House	380		380
3/25/2015	Classic Accents	Name Tags	All Staff		In House	94		94
3/25/2015	Ramirez	Consult W/ ACT. & SS	Kevin, Tammie, Meg	Training	In House	250		250
3/25/2015	Elan	IHCA AANAC	Angie Whitman	Training	Springfield	660		660
3/25/2015	Tracy Sharp	PRN	All Staff		In House	40		40
4/22/2015	Elan	IHNAA Conferece	Meg & Angie	Training	Oak Park	190		190
4/22/2015	Deb Inman	Clinical Training	Nursing Staff	Training	In House	260		260
4/22/2015	Elan	Ass. Of Nutrition & Food	Cory Huddleston	Training	Quincy	399		399
4/22/2015	Classic Accents	Name Tags	All Staff		In House	39		39
5/27/2015	Petty	Conference	Tammy Guile	Training	Bloomington	141		141
6/24/2015	Classic Accents	Name Tags	All Staff		In House	66		66
6/24/2015	Petty	Gas	Cory Huddleston	Travel	Quincy	-		-
7/15/2015	Petty	Gas	Dept Heads	Travel	Peoria	-		-
7/22/2015	Classic Accents	Name Tags	All Staff			116		116
7/15/2015	IL Nursing Home	For Convention	Jori, Rachel	Training		190		190
8/26/2015	Food Safety	Dietary Class	Dietary Staff	Training	On Line Clas	20		20
8/26/2015	Ramirez	Consult with ACT & SS	Kevin, Tammie, Meg	Training		25		25
9/15/2015	Employees	Incentive Program	All Staff			98		98
9/15/2016	Eastern Iowa	Convention	Rachel	Training	Moline	60		60
9/15/2015	Eastern Iowa	Convention	Kevin, Tammie, Meg	Training	Moline	50		50
10/15/2015	Classic Accents	Name Tags	All Staff		In House	61		61
10/15/2015	Petty Cash	Gas	Jori, Rachel, Meg	Travel	Springfield	-		-
10/15/2015	Office Specialist	Office Supply	Cathy Bowton	Training	In House	33		33
10/15/2015	Amsterdam	Employee Folders	Cathy Bowton		In House	251		251
10/15/2015	Employees	Incentive Program	All Staff			25		25
10/15/2015	Classic Accents	Name Tags	All Staff		In House	50		50
11/15/2015	Professional Med	On Line Class	All Staff	Training		896		896
11/15/2015	Classic Accents	Name Tags	All Staff		In House	55		55

Knox County Nursing Home
 0052589
 Seminar Schedule
 12/1/2014-11/30/2015

Date	Payee	Topic	Attendee	Job Description	City/State	Amount	Adjusted	Allowable
11/15/2015	Amsterdam	Employee Folders	Cathy Bowton	Training	In House	222		222
11/15/2015	Petty Cash	Ramirez	Kevin, Tammie, Meg	Training	Moline	170		170
11/15/2015	Employees	Incentive Program	All Staff			25		25
11/15/2015	Classic Accents	Name Tags	All Staff		In House	11		11
						<u>5,558</u>	-	<u>5,558</u>

Knox County Nursing Home
 0052589
 Travel Schedule
 12/1/2014-11/30/2015

Date	Vendor/Description	Purpose	Amount	ADJ	Allowable
Various	County Vehicles Vans	Fuel	5,303		5,303
Various	County Vehicle Mower	Fuel	382		382
Various	County Vehicle Truck	Fuel	835		835
1/28/2015	Tammy Guile/DON	Fuel/Decatur/Conference	143		143
3/25/2015	Angie Whitman/MDS Coord.	Fuel/Springfield/Conference	282		282
4/22/2015	Rachel & Cory/Administartor/Dieta	Fuel/Quincy/Conference	341		341
6/24/2015	Cory Huddleston/Dietary	Fuel/Quincy/Seminar	141		141
7/15/2015	Dept. Heads	Fuel/Peoria/Seminar	479		479
10/15/2015	Jori/Rachel/Meg/Administrative	Fuel/Springfield/Seminar	180		180
11/15/2015	Jori Shull/Office Mgr.	Fuel/Decatur/Mtgs.	160		160
					-
			8,246	\$ -	8,246

Knox County Nursing Home
0052589
Other Admin. Staff Transportation Schedule
12/1/2014-11/30/2015

<u>Date</u>	<u>G/L Acct#</u>	<u>Employee Name</u>	<u>Reference</u>	<u>Amount</u>
Various		Nursing Home Committee Members	Per Diems/Mileage	2,290.00
			Total	<u>2,290.00</u>

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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yr.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,368 Line 110
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 402,104
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 12,812
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
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: Wipfli
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.