

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832 Report Period Beginning: 1/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	15	Sheltered Care (SC)	15	5,490	5
6		ICF/DD 16 or Less			6
7	114	TOTALS	114	41,724	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,604	6,033	2,751	20,388	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		3,991		3,991	12
13	DD 16 OR LESS					13
14	TOTALS	11,604	10,024	2,751	24,379	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.43%

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 2,504

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12-31-16 Fiscal Year: 12-31-16

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 1/01/16 Ending: 12/31/16

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		20,615	392,909	413,524		413,524		413,524		1
2	Food Purchase		126,350		126,350		126,350	(9,663)	116,687		2
3	Housekeeping	86,015	7,971		93,986		93,986		93,986		3
4	Laundry		1,450	8,937	10,387		10,387		10,387		4
5	Heat and Other Utilities			120,334	120,334		120,334	1,134	121,468		5
6	Maintenance	95,755	70,155	66,289	232,199		232,199	4,936	237,135		6
7	Other (specify):* Pastoral	27,215	589	3,555	31,359		31,359		31,359		7
8	TOTAL General Services	208,985	227,130	592,024	1,028,139		1,028,139	(3,593)	1,024,546		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,241,733	142,712	148,623	1,533,068		1,533,068		1,533,068		10
10a	Therapy	316,501	9,360	26,940	352,801		352,801		352,801		10a
11	Activities	78,849	3,942	15,260	98,051		98,051	55	98,106		11
12	Social Services	32,539		744	33,283		33,283		33,283		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*		8,827		8,827		8,827		8,827		15
16	TOTAL Health Care and Programs	1,669,622	164,841	203,567	2,038,030		2,038,030	55	2,038,085		16
	C. General Administration										
17	Administrative	257,049	19,367	465,235	741,651		741,651	(3,575)	738,076		17
18	Directors Fees										18
19	Professional Services			15,732	15,732		15,732	11,769	27,501		19
20	Dues, Fees, Subscriptions & Promotions			42,683	42,683		42,683	1,044	43,727		20
21	Clerical & General Office Expenses			1,867	1,867		1,867	697	2,564		21
22	Employee Benefits & Payroll Taxes			597,349	597,349		597,349	37,335	634,684		22
23	Inservice Training & Education							263	263		23
24	Travel and Seminar			2,378	2,378		2,378	1,960	4,338		24
25	Other Admin. Staff Transportation			3,279	3,279		3,279		3,279		25
26	Insurance-Prop.Liab.Malpractice							414	414		26
27	Other (specify):*										27
28	TOTAL General Administration	257,049	19,367	1,128,523	1,404,939		1,404,939	49,907	1,454,846		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,135,656	411,338	1,924,114	4,471,108		4,471,108	46,369	4,517,477		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 A MERKLE C KNIPPRATH N H

#0021832

Report Period Beginning:

1/01/16

Ending:

12/31/16

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			382,989	382,989		382,989	1,387	384,376			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			110,022	110,022		110,022	(8,858)	101,164			32
33	Real Estate Taxes			2,528	2,528		2,528		2,528			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,249	17,249		17,249	8,049	25,298			35
36	Other (specify):*											36
37	TOTAL Ownership			512,788	512,788		512,788	578	513,366			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			(55,496)	(55,496)		(55,496)		(55,496)			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			161,256	161,256		161,256		161,256			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			105,760	105,760		105,760		105,760			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,135,656	411,338	2,542,662	5,089,656		5,089,656	46,947	5,136,603			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	
	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	(10,220)	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		4		8
9	Non-Straightline Depreciation	(1,025)	30		9
10	Interest and Other Investment Income	(8,858)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(161)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (20,264)		\$	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)	67,211		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 67,211		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 46,947		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

A MERKLE C KNIPPRATH N H

ID# 0021832

Report Period Beginning: 1/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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
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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/16

Ending:

12/31/16

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)	
1	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,220)	557	0	0	0	0	0	0	0	0	0	(9,663)	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	1,134	0	0	0	0	0	0	0	0	0	1,134	5
6	Maintenance	0	3,815	1,121	0	0	0	0	0	0	0	0	4,936	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,220)	5,506	1,121	0	(3,593)	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	55	0	0	0	0	0	0	0	0	0	55	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	55	0	0	0	0	0	0	0	0	0	55	16
	C. General Administration													
17	Administrative	0	(58,861)	55,286	0	0	0	0	0	0	0	0	(3,575)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,769	0	0	0	0	0	0	0	0	0	11,769	19
20	Fees, Subscriptions & Promotions	(161)	1,205	0	0	0	0	0	0	0	0	0	1,044	20
21	Clerical & General Office Expenses	0	697	0	0	0	0	0	0	0	0	0	697	21
22	Employee Benefits & Payroll Taxes	0	30,637	6,698	0	0	0	0	0	0	0	0	37,335	22
23	Inservice Training & Education	0	263	0	0	0	0	0	0	0	0	0	263	23
24	Travel and Seminar	0	1,960	0	0	0	0	0	0	0	0	0	1,960	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	414	0	0	0	0	0	0	0	0	0	414	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(161)	(11,916)	61,984	0	49,907	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,381)	(6,355)	63,105	0	46,369	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 1/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,025)	0	2,412	0	0	0	0	0	0	0	0	1,387	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,858)	0	0	0	0	0	0	0	0	0	0	(8,858)	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	8,049	0	0	0	0	0	0	0	0	8,049	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,883)	0	10,461	0	578	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(20,264)	(6,355)	73,566	0	46,947	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 Commu
		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%	\$ 557	\$	557	1
2	V	5 Utilities		Presence Life Connections	100.00%	1,134		1,134	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	3,815		3,815	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	55		55	4
5	V	17 Admin - Misc. Other	177,026	Presence Life Connections	100.00%	1,936		(175,090)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	116,229		116,229	6
7	V	19 Professional Services		Presence Life Connections	100.00%	11,769		11,769	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	1,205		1,205	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	697		697	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	30,637		30,637	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	263		263	11
12	V	24 Travel		Presence Life Connections	100.00%	1,960		1,960	12
13	V	26 Insurance		Presence Life Connections	100.00%	414		414	13
14	Total		\$ 177,026			\$ 170,671	\$ *	(6,355)	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%	\$ 2,412	\$ 2,412
16	V	32 Interest		Presence Life Connections	100.00%	0	
17	V	34 Rent - Facility		Presence Life Connections	100.00%	0	
18	V	35 Rent - Equipment		Presence Life Connections	100.00%	8,049	8,049
19	V	17 Admin Salaries		Presence Health	100.00%	0	
20	V	22 Employee Benefits		Presence Health	100.00%	6,698	6,698
21	V	30 Depreciation	78,628	Presence Health	100.00%	78,628	
22	V	34 Rent Facility		Presence Health	100.00%	0	
23	V	17 Admin Consulting,Other	288,579	Presence Health	100.00%	258,157	(30,422)
24	V	17 Information Systems Salaries		Presence Health	100.00%	0	
25	V	17 Information Systems - Other		Presence Health	100.00%	61,660	61,660
26	V	17 Admin Salaries		Presence Health	100.00%	0	
27	V	17 Information Systems Salaries		Presence Health	100.00%	18,929	18,929
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%	1,121	1,121
29	V	17 Admin Consulting,Other		Presence Health	100.00%	5,119	5,119
30	V	32 Admin - Interest Expense		Presence Health	100.00%	0	
31	V	39 Ancillary Services - Other	(55,496)	Presence Senior Services Pharmacy	100.00%	(55,496)	
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 311,711			\$ 385,277	\$ * 73,566

* 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:

1/01/16

Ending:

12/31/16

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	Joe Hugar	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Michael Gordon	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace House	Avilla, IN	Independent Living	2
3	Susan Enright	BOD	Presence Nazarethville	Des Plaines	Presence Heritage Lodge	Kankakee	Supportive Living	3
4			Presence Resurrection Life Center	Chicago	Presence Life Connect	Mokena	Management Comp	4
5			Presence Resurrection Nursing & Rehab Center	Park Ridge	Presence Senior Services	Kankakee	Pharmacy	5
6			Presence St Benedict Nursing & Rehab Center	Niles	Presence St. Joseph Academy	Freeport	Adult Day Care	6
7			Presence Villa Scalabrini Nursing & Rehab Center	Northlake	Presence Heritage Day Center	Kankakee	Adult Day Care	7
8			A Merkle C Knipprath Nursing Home	Clifton	Presence St. Vincent	Freeport	Community Living	8
9					Presence Behavioral Health	Broadview	Parent	9
10					Presence Holy Family	Des Plaines	Hospital	10
11					Presence Bethlehem Way	LaGrange Park	Independent Living	11
12					Presence Our Lady of	Chicago	Hospital	12
13					Presence Casa San Carlo	Northlake	Independent Living	13
14					Presence Ambulatory Services	Various	Parent	14
15					Resurrection Development	Chicago	Parent	15
16					Presence Healthcare Services	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care Services	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 Retirement	Chicago	Independent Living	24
25					Resurrection University	Chicago	College	25
26					Presence Health Partners	Various	Parent	26
27					Presence Properties Plus	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Estates	Kankakee	Independent Living	29
30								30

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 1/01/16 Ending: 12/31/16

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	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:

1/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

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	9,455,191	33	\$ 29,753	\$ 177,026	\$ 557	1	
2	5	Utilities	Management Fee Income	9,455,191	33	60,575	177,026	1,134	2	
3	6	Maintenance - Other	Management Fee Income	9,455,191	33	203,785	177,026	3,815	3	
4	11	Activities-Special Events	Management Fee Income	9,455,191	33	2,934	177,026	55	4	
5	17	Admin - Misc. Other	Management Fee Income	9,455,191	33	103,412	177,026	1,936	5	
6	17	Administrative Salaries	Management Fee Income	9,455,191	33	6,207,940	6,207,940	177,026	116,229	6
7	19	Professional Services	Management Fee Income	9,455,191	33	628,607	177,026	11,769	7	
8	20	Dues,Subscriptions	Management Fee Income	9,455,191	33	64,374	177,026	1,205	8	
9	21	Clerical Supplies	Management Fee Income	9,455,191	33	37,236	177,026	697	9	
10	22	Employee Benefits	Management Fee Income	9,455,191	33	1,636,354	177,026	30,637	10	
11	23	Education/Conference	Management Fee Income	9,455,191	33	14,049	177,026	263	11	
12	24	Travel	Management Fee Income	9,455,191	33	104,676	177,026	1,960	12	
13	26	Insurance	Management Fee Income	9,455,191	33	22,118	177,026	414	13	
14	30	Depreciation	Management Fee Income	9,455,191	33	128,835	177,026	2,412	14	
15	32	Interest	Management Fee Income	9,455,191	33	0	177,026	0	15	
16	34	Rent - Facility	Management Fee Income	9,455,191	33	0	177,026	0	16	
17	35	Rent - Equipment	Management Fee Income	9,455,191	33	429,912	177,026	8,049	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 9,674,560	\$ 6,207,940	\$ 181,132	25	

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	6,841,683	23	\$	\$	288,579	\$	1
2	22	Employee Benefits	Operating Expense	6,841,683	23	158,790	288,579	6,698		2
3	30	Depreciation	Operating Expense	1,848,371	23	1,848,371	78,628	78,628		3
4	34	Rent Facility	Operating Expense	6,841,683	23		288,579			4
5	17	Admin Consulting,Other	Operating Expense	6,841,683	23	6,120,437	288,579	258,157		5
6	17	Information Systems Salaries	Operating Expense	6,841,683	23		288,579			6
7	17	Information Systems - Other	Operating Expense	6,841,683	23	1,461,845	288,579	61,660		7
8	17	Admin Salaries	Direct Cost	6,841,683	23		288,579			8
9	17	Information Systems Salaries	Direct Cost	6,841,683	23	448,784	448,784	18,929		9
10	6	Information Systems - Equip Maint	Direct Cost	6,841,683	23	26,573	288,579	1,121		10
11	17	Admin Consulting,Other	Direct Cost	6,841,683	23	121,366	288,579	5,119		11
12	32	Admin - Interest Expense	Direct Cost	6,841,683	23					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					\$ 10,186,166	\$ 448,784	\$ 430,312		25

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	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		\$	\$		(55,496)	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				\$	\$		(55,496)	25

Facility Name & ID Number

A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/16

Ending:

12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	<u>Home Office Allocation</u>						\$	\$			\$	5,119						
2																		
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$			\$	5,119						
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$			\$							
15	TOTALS (line 9+line14)						\$	\$			\$	5,119						

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 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 2016 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:	2011	8	
	2012	9	
	2013	10	
	2014	11	
	2015	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2015 \$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME A MERKLE C KNIPPRATH N H COUNTY IROQUOIS

FACILITY IDPH LICENSE NUMBER 0021832

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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. [X] (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:

A. Land.

Table with 4 columns: Use, Square Feet, Year Acquired, Cost. 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	8,121	187	252,763
10	VARIOUS		1995	177,260	5,933	24	6,250	317	138,201
11	VARIOUS		1998	7,339	320	20	367	47	6,726
12	VARIOUS		2000	53,780	2,090	20	2,055	(35)	36,363
13	VARIOUS		2001	12,094	368	15	368	0	12,094
14	VARIOUS		2002	69,025	3,052	21	3,124	72	45,201
15	VARIOUS		2003	52,773	2,620	20	2,639	19	35,597
16	VARIOUS		2004	54,894	821	13	871	49	51,889
17	VARIOUS		2005	3,058	151	13	151		2,529
18	VARIOUS		2006	12,830	847	15	855	8	8,971
19	VARIOUS		2007	18,065	1,009	17	1,011	2	12,439
20	VARIOUS		2008	141,675	10,086	14	9,860	(226)	85,574
21	VARIOUS		2009	87,276	5,013	16	5,019	5	37,633
22	VARIOUS		2012	3,155	316	10	316		1,420
23									
24	8 PTAC AC UNITS INSULATED WALL		2014	7,124	719	10	712	(7)	1,790
25	ELECTRICAL PROBLEMS WITH AC UN		2014	3,826	376	10	383	7	947
26	FURNACE FOR EAST HALLWAY		2014	2,613	177	15	174	(3)	440
27	MATERIAL LABOR ENTRY HALL DINI		2014	262,443	17,928	15	17,496	(432)	44,317
28	PAINTING TO 6 UNITS AND COMMON		2014	4,000	783	5	800	17	1,977
29	THERAPY ACTIVITY ROOM FLOORING		2014	14,636	970	15	976	6	2,432
30	THERAPY ROOM PTAC UNITS		2014	3,495	343	10	349	6	865
31	WIRELESS INTERNET		2014	73,173	6,976	10	7,317	341	24,342
32									
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

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/16

Ending:

12/31/16

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	ARTWORK	2015	\$ 7,451	\$ 1,064	7	\$ 1,064	\$ (0)	\$ 1,774	37
38	BEDS AND SURFACES	2015	25,321	1,407	18	1,407	(0)	2,345	38
39	BEDSIDE TABLES	2015	5,074	254	20	254		402	39
40	BLANKET WARMER	2015	3,695	246	15	246	0	411	40
41	D.W. PAYNE 2 TON 13 SEER AC UN	2015	3,100	155	20	155		181	41
42	DISHWASHER	2015	3,400	283	12	283	0	472	42
43	ELECTRICAL RE WIRING IN PRIVATE THERAPY SUITE	2015	33,271	1,664	20	1,664		3,188	43
44	GAS FURNACE	2015	3,400	219	15	227	8	556	44
45	HVAC UPGRADES	2015	24,890	1,659	15	1,659	0	2,904	45
46	LABOR FOR INSTALLATION OF LIGH	2015	12,788	823	15	853	30	2,092	46
47	LIGHTING AND FIXTURES	2015	11,268	726	15	751	25	1,830	47
48	NURSE STATION REMODEL	2015	27,146	1,357	20	1,357	(0)	1,697	48
49	PATIENT TRANSPORTATION SLINGS	2015	16,628	810	20	831	22	2,050	49
50	PHONES	2015	21,515	2,151	10	2,151		4,124	50
51	INSTALL NEW WINDOWS/CARPET IN PVT THERAPY SUIT	2015	40,389	2,019	20	2,019	0	3,871	51
52	PTAC A C UNIT	2015	73,265	7,106	10	7,327	221	16,420	52
53	CONSTRUCTION OF 14 PVT THRPY RMS IN ARTHUR HALL	2015	143,565	7,178	20	7,178	(0)	13,758	53
54	NEW PAINT/FLOORING/SINKS IN RESIDENT ROOMS	2015	99,094	4,955	20	4,955	0	5,368	54
55	RESIDENT ROOM RENOVATIONS CEIL	2015	96,479	2,412	40	2,412	0	3,819	55
56	ROOFING AND RELATED WORK	2015	415,700	20,557	20	20,785	228	45,681	56
57	TELEVISIONS AND MOUNTING BRACK	2015	15,584	3,117	5	3,117		4,156	57
58	TUCKPOINTING MASONRY	2015	26,235	1,049	25	1,049		1,749	58
59	WINDOW TREATMENTS	2015	4,655	931	5	931		1,319	59
60	NEW TUCKPOINTING	2015	61,915	3,354	20	3,096	(258)	3,354	60
61									61
62	New Villa Patio	2016	46,432	1,877	40	1,684	(193)	1,877	62
63	RESIDENT ROOM RENOVATIONS - Flooring, Walls, Paint	2016	42,902	2,145	20	2,145	(0)	2,145	63
64	NEW WELL PUMP	2016	8,706	580	15	580	0	580	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,901,281	\$ 189,874		\$ 190,336	\$ 462	\$ 2,696,153	70

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/16

Ending:

12/31/16

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	\$ 1,309,930	\$ 64,262	\$ 66,782	\$ 2,520	20	\$ 997,338	71
72	Current Year Purchases	424,429	48,998	44,991	(4,007)	16	48,998	72
73	Fully Depreciated Assets	220,799	1,227	1,227		19	220,799	73
74	Home Office Allocation		81,040	81,040				74
75	TOTALS	\$ 1,955,158	\$ 195,527	\$ 194,040	\$ (1,487)		\$ 1,267,134	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)	\$ 6,913,439	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 385,401	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 384,376	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,025)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,963,287	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Home Office Allocation				0			5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 25,298 Description: Nursing 13,520; Admin 3,729

(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.

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			
		1	2	3	4
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 1	4141 hrs	\$ 153,589		\$		4,141	\$ 153,589	1
2	Licensed Speech and Language Development Therapist	10a, 1	393 hrs	19,530				393	19,530	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	3760 hrs	143,382				3,760	143,382	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				(55,496)		(55,496)	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Director</u>	10a, 1	0							12
13	Other (specify):									13
14	TOTAL			\$ 316,501		\$	\$ (55,496)	8,294	\$ 261,005	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.

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 13,093,635	\$	1
2	Cash-Patient Deposits	136,639		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	39,798,115		3
4	Supply Inventory (priced at)	1,624,833		4
5	Short-Term Investments	1,515,071		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,808,186		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 58,976,479	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,314,676		12
13	Land	22,947,515		13
14	Buildings, at Historical Cost	236,115,679		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	68,273,740		16
17	Accumulated Depreciation (book methods)	(187,356,794)		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):	2,149,114		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 155,443,930	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 214,420,409	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 7,011,382	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,457,867		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,069		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	590,368		32
33	Accrued Interest Payable	5,594		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Due to Third Parties	(1,918,871)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 32,152,409	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	757,059		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	Conditional Asset Retirement	114,984		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 872,043	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 33,024,452	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 181,395,957	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 214,420,409	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 175,903,003	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	6,676,210	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 182,579,213	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(785,189)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	515,397	11
12	Expenditures for Specific Purposes	(913,464)	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)	\$ (1,183,256)	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)	\$ 181,395,957	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	\$ 4,192,317	1
2	Discounts and Allowances for all Levels	(786,354)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,405,963	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	809,465	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 809,465	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,220	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	69,131	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 79,351	23
D. Non-Operating Revenue			
24	Contributions	830	24
25	Interest and Other Investment Income***	8,858	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,688	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,304,467	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,028,139	31
32	Health Care	2,038,030	32
33	General Administration	1,404,939	33
B. Capital Expense			
34	Ownership	512,788	34
C. Ancillary Expense			
35	Special Cost Centers	(55,496)	35
36	Provider Participation Fee	161,256	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,089,656	40
41	Income before Income Taxes (line 30 minus line 40)**	(785,189)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (785,189)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,455,854	44
45	Private Pay - Net Inpatient Revenue	1,220,676	45
46	Medicare - Net Inpatient Revenue	662,976	46
47	Other-(specify) <u>Insurance</u>	66,457	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,405,963	49

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

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

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

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/16

Ending:

12/31/16

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	1,980	2,148	\$ 80,300	\$ 37.38	1
2	Assistant Director of Nursing	1,960	2,126	65,205	30.67	2
3	Registered Nurses	8,574	9,242	279,769	30.27	3
4	Licensed Practical Nurses	12,829	13,773	341,366	24.79	4
5	CNAs & Orderlies	32,898	35,528	492,267	13.86	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	7,798	8,294	316,501	38.16	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,877	2,097	32,555	15.52	9
10	Activity Assistants	3,947	4,325	48,700	11.26	10
11	Social Service Workers	1,860	2,099	32,539	15.50	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	4,754	5,196	95,755	18.43	17
18	Housekeepers	7,128	7,526	86,014	11.43	18
19	Laundry	0	0	0		19
20	Administrator	1,877	2,085	96,663	46.36	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	2,957	3,404	59,508	17.48	23
24	Clerical	4,063	4,260	48,629	11.42	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health C: Admissions	1,354	1,673	32,667	19.53	32
33	Other(specify) Pastoral	1,030	1,055	27,215	25.80	33
34	TOTAL (lines 1 - 33)	96,886	104,831	\$ 2,135,653 *	\$ 20.37	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			39	
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant	207	12,446	10a,3	41
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant	12	744	11,3	44
45	Social Service Consultant	12	744	12,3	45
46	Other(specify)			46	
47				47	
48				48	
49	TOTAL (lines 35 - 48)	231	\$ 25,934		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	74	\$ 4,397	10,3	50
51	Licensed Practical Nurses			10,3	51
52	Certified Nurse Assistants/Aides	55	1,339	10,3	52
53	TOTAL (lines 50 - 52)	129	\$ 5,736		53

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/16

Ending:

12/31/16

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 \$3,369.72
- (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? 13
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,376 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. \$ 161,256
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. \$ 10,220
- (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