

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832 Report Period Beginning: 1/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,590	5,962	2,095	20,647	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		3,653		3,653	12
13	DD 16 OR LESS					13
14	TOTALS	12,590	9,615	2,095	24,300	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.40%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 2,076

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: 12-31-17 Fiscal Year: 12-31-17

* 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: 1/01/17 Ending: 12/31/17

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		15,485	383,768	399,253		399,253		399,253		1
2	Food Purchase		131,346		131,346		131,346	(8,388)	122,958		2
3	Housekeeping	83,696	12,974		96,670		96,670		96,670		3
4	Laundry		2,817	10,145	12,962		12,962		12,962		4
5	Heat and Other Utilities			135,955	135,955		135,955	827	136,782		5
6	Maintenance	84,871	20,844	92,556	198,271		198,271	48,370	246,641		6
7	Other (specify):* Pastoral	27,951		3,593	31,544		31,544		31,544		7
8	TOTAL General Services	196,518	183,466	626,017	1,006,001		1,006,001	40,809	1,046,810		8
	B. Health Care and Programs										
9	Medical Director			12,800	12,800		12,800		12,800		9
10	Nursing and Medical Records	1,375,543	149,490	278,513	1,803,546		1,803,546		1,803,546		10
10a	Therapy	323,644	16,888	24	340,556		340,556		340,556		10a
11	Activities	80,840	5,235	14,182	100,257		100,257	20	100,277		11
12	Social Services	33,688		868	34,556		34,556		34,556		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*		8,450		8,450		8,450		8,450		15
16	TOTAL Health Care and Programs	1,813,715	180,063	306,387	2,300,165		2,300,165	20	2,300,185		16
	C. General Administration										
17	Administrative	263,601	31,524	461,461	756,586		756,586	(112,273)	644,313		17
18	Directors Fees										18
19	Professional Services			1,526	1,526		1,526	8,138	9,664		19
20	Dues, Fees, Subscriptions & Promotions			37,851	37,851		37,851	1,337	39,188		20
21	Clerical & General Office Expenses			66,844	66,844		66,844	352	67,196		21
22	Employee Benefits & Payroll Taxes			638,490	638,490		638,490	37,864	676,354		22
23	Inservice Training & Education			500	500		500	278	778		23
24	Travel and Seminar			2,315	2,315		2,315	1,633	3,948		24
25	Other Admin. Staff Transportation			5,032	5,032		5,032		5,032		25
26	Insurance-Prop.Liab.Malpractice							2,450	2,450		26
27	Other (specify):*										27
28	TOTAL General Administration	263,601	31,524	1,214,019	1,509,144		1,509,144	(60,221)	1,448,923		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,273,834	395,053	2,146,423	4,815,310		4,815,310	(19,392)	4,795,918		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			361,645	361,645		361,645	5,930	367,575			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			105,858	105,858		105,858	(4,583)	101,275			32
33	Real Estate Taxes			(2,490)	(2,490)		(2,490)		(2,490)			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,020	9,020		9,020	7,765	16,785			35
36	Other (specify):*											36
37	TOTAL Ownership			474,033	474,033		474,033	9,112	483,145			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			371,173	371,173		371,173		371,173			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,396	165,396		165,396		165,396			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			536,569	536,569		536,569		536,569			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,273,834	395,053	3,157,025	5,825,912		5,825,912	(10,280)	5,815,632			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	(8,860)	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	3,161	30		9
10	Interest and Other Investment Income	(4,583)	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		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)	\$ (10,282)		\$	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)		1 17	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (10,281)		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: 1/01/17

Ending: 12/31/17

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:

1/01/17

Ending:

12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,860)	472	0	0	0	0	0	0	0	0	0	(8,388)	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	827	0	0	0	0	0	0	0	0	0	827	5
6	Maintenance	0	3,828	44,542	0	0	0	0	0	0	0	0	48,370	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,860)	5,127	44,542	0	40,809	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	20	0	0	0	0	0	0	0	0	0	20	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	20	0	0	0	0	0	0	0	0	0	20	16
C. General Administration														
17	Administrative	1	(33,961)	(78,313)	0	0	0	0	0	0	0	0	(112,273)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,138	0	0	0	0	0	0	0	0	0	8,138	19
20	Fees, Subscriptions & Promotions	0	1,337	0	0	0	0	0	0	0	0	0	1,337	20
21	Clerical & General Office Expenses	0	352	0	0	0	0	0	0	0	0	0	352	21
22	Employee Benefits & Payroll Taxes	0	4,093	33,771	0	0	0	0	0	0	0	0	37,864	22
23	Inservice Training & Education	0	278	0	0	0	0	0	0	0	0	0	278	23
24	Travel and Seminar	0	1,633	0	0	0	0	0	0	0	0	0	1,633	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	2,450	0	0	0	0	0	0	0	0	0	2,450	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	1	(15,680)	(44,542)	0	(60,221)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,859)	(10,533)	0	0	0	0	0	0	0	0	0	(19,392)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	3,161	0	2,769	0	0	0	0	0	0	0	0	5,930	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,583)	0	0	0	0	0	0	0	0	0	0	(4,583)	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	7,765	0	0	0	0	0	0	0	0	7,765	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,422)	0	10,534	0	9,112	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)	(10,281)	(10,533)	10,534	0	(10,280)	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%	\$ 472	\$	472	1
2	V	5 Utilities		Presence Life Connections	100.00%	827		827	2
3	V	6 Maintenance - Other		Presence Life Connections	100.00%	3,828		3,828	3
4	V	11 Activities-Special Events		Presence Life Connections	100.00%	20		20	4
5	V	17 Admin - Misc. Other	123,074	Presence Life Connections	100.00%	(20)		(123,094)	5
6	V	17 Administrative Salaries		Presence Life Connections	100.00%	89,133		89,133	6
7	V	19 Professional Services		Presence Life Connections	100.00%	8,138		8,138	7
8	V	20 Dues,Subscriptions		Presence Life Connections	100.00%	1,337		1,337	8
9	V	21 Clerical Supplies		Presence Life Connections	100.00%	352		352	9
10	V	22 Employee Benefits		Presence Life Connections	100.00%	4,093		4,093	10
11	V	23 Education/Conference		Presence Life Connections	100.00%	278		278	11
12	V	24 Travel		Presence Life Connections	100.00%	1,633		1,633	12
13	V	26 Insurance		Presence Life Connections	100.00%	2,450		2,450	13
14	Total		\$ 123,074			\$ 112,541	\$ *	(10,533)	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%	\$ 2,769	\$ 2,769
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%	7,765	7,765
19	V	17 Admin Salaries		Presence Health	100.00%	187,570	187,570
20	V	22 Employee Benefits		Presence Health	100.00%	33,771	33,771
21	V	30 Depreciation	78,834	Presence Health	100.00%	78,834	
22	V	34 Rent Facility		Presence Health	100.00%	0	
23	V	17 Admin Consulting,Other	338,387	Presence Health	100.00%	111,187	(227,200)
24	V	17 Information Systems Salaries		Presence Health	100.00%	0	
25	V	17 Information Systems - Other		Presence Health	100.00%	0	
26	V	17 Admin Salaries		Presence Health	100.00%	0	
27	V	17 Information Systems Salaries		Presence Health	100.00%	0	
28	V	6 Information Systems - Equip Maint		Presence Health	100.00%	44,542	44,542
29	V	17 Admin Consulting,Other		Presence Health	100.00%	0	
30	V	32 Admin - Interest Expense	105,858	Presence Health	100.00%	105,858	
31	V	17 Admin Int Inc Offset		Presence Health	100.00%	(38,683)	(38,683)
32	V	39 Ancillary Services - Other	371,173	Presence Senior Services Pharmacy	100.00%	371,173	
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 894,252			\$ 904,786	\$ * 10,534

* 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	Mike Gordon	BOD	Presence Heritage Village	Kankakee	Presence Hospitals	Various	Hospital	1
2	Sue Enright	BOD	Presence Maryhaven Nursing & Rehab Center	Glenview	Laverna Terrace House	Avilla, IN	Independent Living	2
3	Wendell Provost	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	Kankakee	Adult Day Care	7
8					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 W	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 S	Various	Parent	14
15					Resurrection Developm	Chicago	Parent	15
16					Presence Healthcare S	Various	Parent	16
17					Presence Health Care	Various	Physicians	17
18					Presence Home Care S	Various	Home Health	18
19					Presence Resurrection	Chicago	Hospital	19
20					Resurrection Services	Des Plaines	Parent	20
21					Presence Saint Francis	Evanston	Hospital	21
22					Presence Saint Joseph	Chicago	Hospital	22
23					Presence Saints Mary	Chicago	Hospital	23
24					Resurrection Retirement	Chicago	Independent Living	24
25					Resurrection Universit	Chicago	College	25
26					Presence Health Partn	Various	Parent	26
27					Presence Properties PI	Bolingbrook	Parent	27
28					Presence Ventures, Inc	Bolingbrook	Parent	28
29					Presence Heritage Esta	Kankakee	Independent Living	29
30								30

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 1/01/17 Ending: 12/31/17

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									\$		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: 1/01/17 Ending: 12/31/17

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	Unit of Allocation	Number of	Total Indirect	Amount of Salary	Facility	Allocation			
Line	(i.e.,Days, Direct Cost,	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6			
Reference	Square Feet)	Allocated Among	Allocated	in Column 6					
Item	Total Units								
1	2	Food	Management Fee Income	5,620,989	33	\$ 21,575	\$ 123,074	\$ 472	1
2	5	Utilities	Management Fee Income	5,620,989	33	37,782	123,074	827	2
3	6	Maintenance - Other	Management Fee Income	5,620,989	33	174,812	123,074	3,828	3
4	11	Activities-Special Events	Management Fee Income	5,620,989	33	894	123,074	20	4
5	17	Admin - Misc. Other	Management Fee Income	5,620,989	33	(911)	123,074	(20)	5
6	17	Administrative Salaries	Management Fee Income	5,620,989	33	4,070,831	4,070,831	123,074	89,133
7	19	Professional Services	Management Fee Income	5,620,989	33	371,695	123,074	8,138	7
8	20	Dues,Subscriptions	Management Fee Income	5,620,989	33	61,085	123,074	1,337	8
9	21	Clerical Supplies	Management Fee Income	5,620,989	33	16,056	123,074	352	9
10	22	Employee Benefits	Management Fee Income	5,620,989	33	186,921	123,074	4,093	10
11	23	Education/Conference	Management Fee Income	5,620,989	33	12,708	123,074	278	11
12	24	Travel	Management Fee Income	5,620,989	33	74,575	123,074	1,633	12
13	26	Insurance	Management Fee Income	5,620,989	33	111,873	123,074	2,450	13
14	30	Depreciation	Management Fee Income	5,620,989	33	126,474	123,074	2,769	14
15	32	Interest	Management Fee Income	5,620,989	33	0	123,074	0	15
16	34	Rent - Facility	Management Fee Income	5,620,989	33	0	123,074	0	16
17	35	Rent - Equipment	Management Fee Income	5,620,989	33	354,619	123,074	7,765	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 5,620,989	\$ 4,070,831	\$ 123,075	25

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/17

Ending: 12/31/17

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	13,936,478	35	\$ 7,725,094	\$ 7,725,094	338,387	\$ 187,570	1
2	22	Employee Benefits	Operating Expense	13,936,478	35	1,390,855		338,387	33,771	2
3	30	Depreciation	Direct Cost	3,515,581	35	3,515,581		78,834	78,834	3
4	34	Rent Facility	Operating Expense	13,936,478	35			338,387		4
5	17	Admin Consulting,Other	Operating Expense	13,936,478	35	4,579,250		338,387	111,187	5
6	17	Information Systems Salaries	Operating Expense	13,936,478	35			338,387		6
7	17	Information Systems - Other	Operating Expense	13,936,478	35			338,387		7
8	17	Admin Salaries	Operating Expense	13,936,478	35			338,387		8
9	17	Information Systems Salaries	Operating Expense	13,936,478	35			338,387		9
10	6	Information Systems - Equip Main	Operating Expense	13,936,478	35	1,834,459		338,387	44,542	10
11	17	Admin Consulting,Other	Operating Expense	13,936,478	35			338,387		11
12	32	Admin - Interest Expense	Direct Cost	3,221,289	35	3,221,289		105,858	105,858	12
13	17	Admin Int Inc Offset	Operating Expense	13,936,478	35	(1,593,180)		338,387	(38,683)	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					\$ 20,673,348	\$ 7,725,094		\$ 523,079	25

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/17

Ending: 12/31/17

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 Senior Services Pharmacy
 Street Address 670 North Convent Street
 City / State / Zip Code Bourbonnais, Illinois 60914
 Phone Number (815)936-3644
 Fax Number (815)936-3238

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		\$	\$		\$ 371,173	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				\$	\$		\$ 371,173	25

Facility Name & ID Number

A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/17

Ending:

12/31/17

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							\$	\$				\$						
2																		
3																		
4																		
5																		
	Working Capital																	
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$				\$						
	B. Non-Facility Related*																	
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$	\$				\$						

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 2016 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 2017 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:	2012	<u> </u>	8
	2013	<u> </u>	9
	2014	<u> </u>	10
	2015	<u> </u>	11
	2016	<u> </u>	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$ <u> </u>	13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u>	14
15	LESS REFUND FROM LINE 6	\$ <u> </u>	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u>	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 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 2016 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 2016.

(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	\$ _____	\$ _____

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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:

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	\$	40	\$	\$	\$ 773,036	4
5	15	2013	1992	1,465,015	35,329	30	35,581	252	1,066,481	5
6										6
7										7
8										8
	Improvement Type**									
9	VARIOUS		1986	324,830	7,934	40	8,121	187	260,697	9
10	VARIOUS		1995	177,260	5,933	24	6,250	317	144,134	10
11	VARIOUS		1998	7,339	320	20	367	47	7,046	11
12	VARIOUS		2000	53,780	2,090	20	2,055	(35)	38,453	12
13	VARIOUS		2001	12,094		15			12,094	13
14	VARIOUS		2002	69,025	2,853	21	2,908	55	48,054	14
15	VARIOUS		2003	52,773	2,620	20	2,639	19	38,217	15
16	VARIOUS		2004	54,894	821	13	871	50	52,710	16
17	VARIOUS		2005	3,058	151	13	151		2,680	17
18	VARIOUS		2006	12,830	847	15	855	8	9,818	18
19	VARIOUS		2007	18,065	575	17	577	2	13,014	19
20	VARIOUS		2008	141,675	10,086	14	9,860	(226)	95,661	20
21	VARIOUS		2009	87,276	5,013	16	5,019	6	42,646	21
22	VARIOUS		2012	3,155	316	10	316		1,735	22
23										23
24	8 PTAC AC UNITS INSULATED WALL		2014	7,124	719	10	712	(7)	2,509	24
25	ELECTRICAL PROBLEMS WITH AC UN		2014	3,826	376	10	383	7	1,323	25
26	FURNACE FOR EAST HALLWAY		2014	2,613	177	15	174	(3)	617	26
27	MATERIAL LABOR ENTRY HALL DINI		2014	262,443	17,928	15	17,496	(432)	62,245	27
28	PAINTING TO 6 UNITS AND COMMON		2014	4,000	783	5	800	17	2,760	28
29	THERAPY ACTIVITY ROOM FLOORING		2014	14,636	970	15	976	6	3,401	29
30	THERAPY ROOM PTAC UNITS		2014	3,495	343	10	349	6	1,208	30
31	WIRELESS INTERNET		2014	73,173	6,976	10	7,317	341	31,318	31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/17

Ending:

12/31/17

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	\$ 2,838	37
38	BEDS AND SURFACES	2015	25,321	1,407	18	1,407	(0)	3,751	38
39	BEDSIDE TABLES	2015	5,074	254	20	254	(0)	655	39
40	BLANKET WARMER	2015	3,695	246	15	246	0	657	40
41	D.W. PAYNE 2 TON 13 SEER AC UN	2015	3,100	155	20	155		336	41
42	DISHWASHER	2015	3,400	283	12	283	0	756	42
43	ELECTRICAL RE WIRING IN PRIVATE THERAPY SUITE	2015	33,271	1,664	20	1,664	(0)	4,852	43
44	GAS FURNACE	2015	3,400	219	15	227	8	775	44
45	HVAC UPGRADES	2015	24,890	1,659	15	1,659	0	4,563	45
46	LABOR FOR INSTALLATION OF LIGH	2015	12,788	823	15	853	30	2,914	46
47	LIGHTING AND FIXTURES	2015	11,268	726	15	751	25	2,556	47
48	NURSE STATION REMODEL	2015	27,146	1,357	20	1,357	0	3,054	48
49	PATIENT TRANSPORTATION SLINGS	2015	16,628	810	20	831	21	2,860	49
50	PHONES	2015	21,515	2,151	10	2,151	0	6,275	50
51	INSTALL NEW WINDOWS/CARPET IN PVT THERAPY SUIT	2015	40,389	2,019	20	2,019	0	5,890	51
52	PTAC A C UNIT	2015	73,265	7,106	10	7,327	221	23,526	52
53	CONSTRUCTION OF 14 PVT THRPY RMS IN ARTHUR HALL	2015	143,565	7,178	20	7,178	0	20,937	53
54	NEW PAINT/FLOORING/SINKS IN RESIDENT ROOMS	2015	99,094	4,955	20	4,955	(0)	10,322	54
55	RESIDENT ROOM RENOVATIONS CEIL	2015	96,479	2,412	40	2,412	(0)	6,231	55
56	ROOFING AND RELATED WORK	2015	415,700	20,557	20	20,785	228	66,238	56
57	TELEVISIONS AND MOUNTING BRACK	2015	15,584	3,117	5	3,117	(0)	7,273	57
58	TUCKPOINTING MASONRY	2015	26,235	1,049	25	1,049	0	2,798	58
59	WINDOW TREATMENTS	2015	4,655	931	5	931		2,250	59
60	NEW TUCKPOINTING	2015	61,915	3,096	20	3,096	(0)	6,449	60
61									61
62	New Villa Patio	2016	46,432	2,322	40	2,322		4,199	62
63	RESIDENT ROOM RENOVATIONS - Flooring, Walls, Paint	2016	42,902	2,145	20	2,145	0	4,290	63
64	NEW WELL PUMP	2016	8,706	580	15	580	0	1,161	64
65									65
66	NEW CONCRETE PATIO & WALKWAY	2017	13,848	231	20	231		231	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,915,129	\$ 173,676		\$ 174,828	\$ 1,152	\$ 2,910,494	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:

1/01/17

Ending:

12/31/17

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	\$ 1,132,289	\$ 104,616	\$ 106,625	\$ 2,009	13	\$ 552,552	71
72	Current Year Purchases	23,102	845	845		14	845	72
73	Fully Depreciated Assets	799,312	3,674	3,674		12	799,312	73
74	Home Office Allocation		81,603	81,603				74
75	TOTALS	\$ 1,954,703	\$ 190,738	\$ 192,747	\$ 2,009		\$ 1,352,709	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)	\$ 6,926,832	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 364,414	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 367,575	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,161	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,263,203	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								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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 16,785 Description: Nursing 442; Admin 8,578; Home Office 7,765

(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	4252 hrs	\$ 159,011		\$		4,252	\$ 159,011	1
2	Licensed Speech and Language Development Therapist	10a, 1	381 hrs	18,428				381	18,428	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1	3718 hrs	146,205				3,718	146,205	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				371,173		371,173	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	0						12
13	Other (specify): _____									13
14	TOTAL			\$ 323,644		\$	\$ 371,173	8,351	\$ 694,817	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17**

(last day of reporting year)

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	\$ 5,899,845	\$	1
2	Cash-Patient Deposits	144,830		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	32,268,677		3
4	Supply Inventory (priced at)	1,411,420		4
5	Short-Term Investments	116,835		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	13,801,325		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 53,642,932	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	11,514,361		12
13	Land	22,947,515		13
14	Buildings, at Historical Cost	248,853,412		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	58,926,661		16
17	Accumulated Depreciation (book methods)	(193,707,894)		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):	2,788,546		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 151,322,601	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 204,965,533	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,918,826	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,250,139		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,490		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	587,749		32
33	Accrued Interest Payable	4,849		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Third Parties	(2,518,894)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 25,270,159	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	629,027		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	47,219		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 676,246	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 25,946,405	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 179,019,128	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 204,965,533	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 181,395,957	1
2	Restatements (describe):		2
3			3
4	Adj. to reconcile consolidated equity & consolidated income	(814,438)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 180,581,519	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,581,452)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,390,900	11
12	Expenditures for Specific Purposes	(1,371,839)	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)	\$ (1,562,391)	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)	\$ 179,019,128	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning: 1/01/17

Ending: 12/31/17

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,510,888	1
2	Discounts and Allowances for all Levels	(1,363,369)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,147,519	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	677,234	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 677,234	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	8,860	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	368,515	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)	\$ 377,375	23
D. Non-Operating Revenue			
24	Contributions	4,372	24
25	Interest and Other Investment Income***	4,583	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,955	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	33,377	27
28	Miscellaneous Income		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 33,377	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,244,460	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,006,001	31
32	Health Care	2,300,165	32
33	General Administration	1,509,144	33
B. Capital Expense			
34	Ownership	474,033	34
C. Ancillary Expense			
35	Special Cost Centers	371,173	35
36	Provider Participation Fee	165,396	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,825,912	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,581,452)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,581,452)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,604,744	44
45	Private Pay - Net Inpatient Revenue	1,107,927	45
46	Medicare - Net Inpatient Revenue	418,964	46
47	Other-(specify) <u>Insurance</u>	15,884	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,147,519	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:

1/01/17

Ending:

12/31/17

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	2,024	2,208	\$ 85,549	\$ 38.75	1
2	Assistant Director of Nursing	1,976	2,064	65,754	31.86	2
3	Registered Nurses	9,148	9,766	308,412	31.58	3
4	Licensed Practical Nurses	12,520	13,583	354,470	26.10	4
5	CNAs & Orderlies	35,147	37,678	566,578	15.04	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	7,751	8,351	323,644	38.76	7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,811	2,085	33,293	15.97	9
10	Activity Assistants	3,066	3,233	36,705	11.35	10
11	Social Service Workers	1,861	2,100	33,772	16.08	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	5,111	5,408	96,103	17.77	17
18	Housekeepers	6,551	7,088	83,696	11.81	18
19	Laundry	0	0	0		19
20	Administrator	1,864	2,080	98,350	47.28	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	1,915	2,135	38,456	18.01	23
24	Clerical	4,463	4,993	55,458	11.11	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	3,111		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	7	7	161	23.00	31
32	Other Health C: Admissions	1,928	2,120	62,371	29.42	32
33	Other(specify) <u>Pastoral</u>	996	1,056	27,951	26.47	33
34	TOTAL (lines 1 - 33)	98,139	105,955	\$ 2,273,834 *	\$ 21.46	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	12,800	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				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	868	11,3	44
45	Social Service Consultant	14	868	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	28	\$ 14,536		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	409	\$ 29,761	10,3	50
51	Licensed Practical Nurses	494	23,593	10,3	51
52	Certified Nurse Assistants/Aides	6,802	173,428	10,3	52
53	TOTAL (lines 50 - 52)	7,705	\$ 226,782		53

Facility Name & ID Number A MERKLE C KNIPPRATH N H

0021832

Report Period Beginning:

1/01/17

Ending:

12/31/17

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. 4815
- (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? 14
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,549 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. \$ 165,396
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? YES For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,860
- (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