		FOR BHF USE				

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0010561

Facility Name: Knox County Nursing Home

Address: 800 North Market St (Number) Knoxville (City) 61448 (Zip Code)

County: Knox

Telephone Number: (309) 289-2338 **Fax #** (309) 289-8255

HFS ID Number:

Date of Initial License for Current Owners: 10/23/1946

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler Telephone Number: (847) 940-3269
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/2015 to 11/30/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Andrew B. Cutler Managing Director
	(Firm Name & Address)	FGMK, LLC 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015
	(Telephone)	(847) 374-0400 Fax # (847) 374-0420

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	169	Skilled (SNF)	169	61,854	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	169	TOTALS	169	61,854	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,958	2,958	8
9	SNF/PED					9
10	ICF	26,451	19,622		46,073	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,451	19,622	2,958	49,031	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.27%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/28/1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date ______ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 169 and days of care provided 2,348

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number: Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	456,323	29,396	11,790	497,509		497,509		497,509			1
2	Food Purchase		313,289		313,289		313,289	(15,694)	297,595			2
3	Housekeeping	257,395	28,278		285,673		285,673		285,673			3
4	Laundry	76,556	18,816	107,690	203,062		203,062		203,062			4
5	Heat and Other Utilities			227,292	227,292		227,292		227,292			5
6	Maintenance	137,838	956	138,872	277,666		277,666	(20,329)	257,337			6
7	Other (specify):*											7
8	**TOTAL General Services**	928,112	390,735	485,644	1,804,491		1,804,491	(36,023)	1,768,468			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	3,978,297	203,699	13,203	4,195,199		4,195,199		4,195,199			10
10a	Therapy		859		859		859		859			10a
11	Activities	111,854	5,154		117,008		117,008		117,008			11
12	Social Services	120,363	444		120,807		120,807		120,807			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,210,514	210,156	22,203	4,442,873		4,442,873		4,442,873			16
	C. General Administration											
17	Administrative	73,653			73,653		73,653		73,653			17
18	Directors Fees											18
19	Professional Services			48,096	48,096		48,096		48,096			19
20	Dues, Fees, Subscriptions & Promotions			39,964	39,964		39,964	(6,232)	33,732			20
21	Clerical & General Office Expenses	195,864	12,239	228,452	436,555		436,555	(210,252)	226,303			21
22	Employee Benefits & Payroll Taxes			1,817,017	1,817,017		1,817,017	478,005	2,295,022			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,305	7,305		7,305	(230)	7,075			24
25	Other Admin. Staff Transportation			2,456	2,456		2,456		2,456			25
26	Insurance-Prop.Liab.Malpractice			16,992	16,992		16,992		16,992			26
27	Other (specify):*											27
28	**TOTAL General Administration**	269,517	12,239	2,160,282	2,442,038		2,442,038	261,291	2,703,329			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,408,143	613,130	2,668,129	8,689,402		8,689,402	225,268	8,914,670			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			262,166	262,166		262,166	36,249	298,415			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,656	8,656		8,656		8,656			35
36	Other (specify):*											36
37	TOTAL Ownership			270,822	270,822		270,822	36,249	307,071			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		121,928	467,725	589,653		589,653		589,653			39
40	Barber and Beauty Shops	27,036	1,564		28,600		28,600	(6,380)	22,220			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			372,870	372,870		372,870		372,870			42
43	Other (specify):*			757	757		757	(757)				43
44	TOTAL Special Cost Centers	27,036	123,492	841,352	991,880		991,880	(7,137)	984,743			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,435,179	736,622	3,780,303	9,952,104		9,952,104	254,380	10,206,484			45

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(15,694)	2		4
5	Telephone, TV & Radio in Resident Rooms	(726)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	36,249	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(210,216)	21		24
25	Fund Raising, Advertising and Promotional	(6,232)	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	(27,006)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (223,625)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (223,625)		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 Yes	2 No	3 Amount	4 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

Knox County Nursing Home

ID# 0010561

Report Period Beginning: 12/1/2015

Ending: 11/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beauty Revenue Offset	$ (6,380)	40	1
2	Non-Allowable Bank Charges	(36)	21	2
3	Undocumented Seminar Expense	(230)	24	3
4	Capitalized R&M	(19,603)	6	4
5	Non-Allowable County Farm Tax	(757)	43	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
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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**	(27,006)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(15,694)	0	0	0	0	0	0	0	0	0	0	(15,694)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(20,329)	0	0	0	0	0	0	0	0	0	0	(20,329)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(36,023)	0	0	0	0	0	0	0	0	0	0	(36,023)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(6,232)	0	0	0	0	0	0	0	0	0	0	(6,232)	20
21	Clerical & General Office Expenses	(210,252)	0	0	0	0	0	0	0	0	0	0	(210,252)	21
22	Employee Benefits & Payroll Taxes	0	478,005	0	0	0	0	0	0	0	0	0	478,005	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(230)	0	0	0	0	0	0	0	0	0	0	(230)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(216,714)	478,005	0	0	0	0	0	0	0	0	0	261,291	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(252,737)	478,005	0	0	0	0	0	0	0	0	0	225,268	29

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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

	Capital Expense D. Ownership	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)	
30	Depreciation	36,249	0	0	0	0	0	0	0	0	0	0	36,249	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	36,249	0	0	0	0	0	0	0	0	0	0	36,249	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(6,380)	0	0	0	0	0	0	0	0	0	0	(6,380)	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):*	(757)	0	0	0	0	0	0	0	0	0	0	(757)	43
44	**TOTAL Special Cost Centers**	(7,137)	0	0	0	0	0	0	0	0	0	0	(7,137)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(223,625)	478,005	0	0	0	0	0	0	0	0	0	254,380	45

Facility Name & ID Number: Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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
Knox County	100%	None		None		

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. [X] 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	19	Portion of IT Support	$ 26,649	Knox County		$ 26,649	$	1
2	V	22	IMRF County		Knox County		318,670	318,670	2
3	V	22	Payroll Taxes County		Knox County		159,335	159,335	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 26,649			$ 504,654	$ * 478,005	14

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Richard Conklin	BOD						1
2	Cheryl Nache	BOD						2
3	Lyle Johnson	BOD						3
4	David Amor	BOD						4
5	John Hunigan	BOD						5
6	Robert Bondi	BOD						6
7	Michael Nelson	BOD						7
8	Pamela Davidson	BOD						8
9	Trisha Hurst	BOD						9
10	Sara Varner	BOD						10
11	Jared Hawkinson	BOD						11
12	David Erickson	BOD						12
13	Todd Shreves	BOD						13
14	Ricardo D. Sandoval	BOD						14
15	Brian Friedrich	BOD						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	County Board Members		Committee	0.00	None	Various		Per Diem/	$		1
2								Mileage	2,456	25-3	2
3											3
4											4
5											5
6											6
7											7
8	Knox County holds Committee Meetings related to the Nursing Home										8
9	Per Diems and Mileage are paid separately by the nursing home.										9
10											10
11											11
12											12
13								TOTAL	$ 2,456		13

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

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 1/30/2016

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 X NO

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Portion of IT Support	Direct Cost	169		$ 26,649	$	169	$ 26,649	1
2	22	IMRF- County	Direct Cost	169		318,670		169	318,670	2
3	22	Payroll Tax-County	Direct Cost	169		159,335		169	159,335	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					$ 504,654	$		$ 504,654	25

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	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	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

* 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.)

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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.

Item	Amount	Line
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:	Amount	Line
2011		8
2012		9
2013		10
2014		11
2015		12

Facility is exempt from paying real estate taxes

	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 Knox County Nursing Home COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0010561

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

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

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

Enter the tax index number and real estate tax assessed for 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

None

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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	1,481,040	1966	$ 156,600	1
2					2
3	TOTALS	1,481,040		$ 156,600	3

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	169		1966	1966	$ 1,842,192	$	50	$ 36,844	$ 36,844	$ 1,861,488	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1966	46,724		20	934	934	44,263	9
10	Various			1971	146,065		20			146,065	10
11	Various			1980	9,972		20			9,972	11
12	Various			1981	650		20			650	12
13	Various			1983	14,762		20			14,762	13
14	Various			1984	31,009		20			31,009	14
15	Various			1985	73,090		20			73,090	15
16	Various			1986	141,506		20			141,506	16
17	Various			1987	142,693		20			142,693	17
18	Various			1988	60,820		20			60,820	18
19	Various			1989	47,469		20			47,469	19
20	Various			1990	29,117		20			29,117	20
21	Various			1991	17,547		20			17,547	21
22	Various			1992	197,932		20			197,932	22
23	Various			1993	97,234		20			97,234	23
24	Various			1994	45,232		20			45,232	24
25	Various			1995	58,215		20			58,215	25
26	Various			1996	76,390		20			76,390	26
27	Various			1997	26,377		20			26,377	27
28	Various			1998	39,334		20	1,676	1,676	36,838	28
29	Various			1999	21,237		20			21,237	29
30	Various			2000	20,496		20			20,496	30
31	Various			2001	1,395		20			1,395	31
32	Various			2003	161,240		20	8,448	8,448	97,345	32
33	Various			2004	116,328		20	6,827	6,827	70,298	33
34	Various			2005	327,652		20	16,383	16,383	163,173	34
35	Various			2006	1,002,155		20	49,800	49,800	449,122	35
36	Various			2007	480,150		20	4,856	4,856	38,849	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2008	$ 396,911	$	20	$ 7,473	$ 7,473	$ 59,789	37
38	Various	2009	386,135		20	12,487	12,487	98,675	38
39	Various	2010	34,807		20	1,758	1,758	11,598	39
40	Various	2011	1,483,738		20	74,187	74,187	173,418	40
41	Various	2012	184,474		20	9,224	9,224	34,110	41
42	Sidewalk Replacement	2013	4,900		20	245	245	817	42
43	Additional Boiler Project	2013	17,876		20	894	894	2,980	43
44	Gazebo Roof	2013	4,800		20	240	240	780	44
45	Ice Machine - (Plumbing Roughed-In)	2013	4,687		20	234	234	741	45
46	Garage Roof	2013	3,500		20	175	175	554	46
47	Flooring Office/Reception	2013	4,353		20	218	218	889	47
48	Parking Lot Rehab (Repairs, Sealcoating, remarking)	2014	58,684		20	2,934	2,934	6,846	48
49	Room 405 (Plumbing, Carpet, And Walls)	2014	20,438		20	1,022	1,022	2,640	49
50	Light Pole in Parking Lot	2014	5,013		20	251	251	648	50
51	Wing 2 Faucet Replacement	2014	4,456		20	223	223	576	51
52	Wing 4 Fire Door	2014	2,624		20	131	131	273	52
53	Sidewalk Replacement	2014	4,500		20	225	225	506	53
54	Kitchen Renovation (Flooring , Plumbing, Drywall, Lighting)	2014	84,258		20	4,213	4,213	8,777	54
55	Wings 1,2,3,4 Heating Units Replacement	2014	4,847		20	242	242	706	55
56	Wings 1,2,3,4 Heating Units Replacement	2014	20,138		20	1,007	1,007	3,021	56
57	Fire Door - Wing 4	2014	2,624		20	131	131	262	57
58	Kitchen Remodel - Feed for Mobil Kitchen	2015	3,378		20	169	169	268	58
59	Replace Relief Valve/Steam Header/Traps - Boiler	2015	27,342		20	1,367	1,367	2,620	59
60	Plumbing Boiler Room	2015	3,773		20	189	189	220	60
61	Hot Water Piping	2015	3,406		20	170	170	184	61
62	Water Meter	2016	7,798		20	195	195	195	62
63	Emergency Electrical System	2016	34,013		20	850	850	850	63
64	Hot Water Line Repairs	2016	4,992		20	125	125	125	64
65	Remodel Patient RMs 203&204, Walls, Flooring, Paint	2016	6,932		20	173	173	173	65
66									66
67									67
68									68
69	Book Depreciation			262,166			(262,166)		69
70	TOTAL (lines 4 thru 69)		$ 8,100,380	$ 262,166		$ 246,520	$ (15,646)	$ 4,433,825	70

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	$ 1,877,527	$	$ 50,551	$ 50,551	5	$ 1,416,299	71
72	Current Year Purchases	7,679		768	768		768	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,885,206	$	$ 51,319	$ 51,319		$ 1,417,067	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Ford Escort	1993	$ 10,827	$	$	$		$	76
77		Ford Truck	1995	17,024						77
78		Van	2005	78,436						78
79		Truck Overhaul	2014	2,882		576	576	5	1,344	79
80	TOTALS			$ 109,169	$	$ 576	$ 576		$ 1,344	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,251,355	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 262,166	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 298,415	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 36,249	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,852,236	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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: $ 8,656 Description: Postage Meter- $728, Oxygen Tanks- $1350, Copy Machine/Fax- $5578, Timeclock-$1000
    (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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

		1	2	3	4	5	6	7	8	
	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	39-3	hrs	$		$ 203,831	$		$ 203,831	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			95,126			95,126	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			168,768			168,768	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				112,895		112,895	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen/Supplies						9,033		9,033	12
13	Other (specify):									13
14	TOTAL			$		$ 467,725	$ 121,928		$ 589,653	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2016 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 628,712	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (319,639))	1,765,299		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Porperty Tax Receivable	796,965		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,190,976	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	615,714		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	9,190,518		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(6,395,754)		17
18	Deferred Charges	1,670,747		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,081,225	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,272,201	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 214,916	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,727,504		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due To Others	23,466		36
37	Deferred Property Taxes	788,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,753,886	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,753,886	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,518,315	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,272,201	$	48

*(See instructions.)

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,434,637	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,434,637	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(916,322)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (916,322)	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)**	$ 5,518,315	24 *

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,053,952	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,053,952	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	189,039	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 189,039	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,847	12
13	Barber and Beauty Care	6,380	13
14	Non-Patient Meals	11,847	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	34,548	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 56,622	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(124,634)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (124,634)	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	See Attached	860,803	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 860,803	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,035,782	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,804,491	31
32	Health Care	4,442,873	32
33	General Administration	2,442,038	33
	B. Capital Expense		
34	Ownership	270,822	34
	C. Ancillary Expense		
35	Special Cost Centers	619,010	35
36	Provider Participation Fee	372,870	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,952,104	40
41	**Income before Income Taxes (line 30 minus line 40)****	(916,322)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (916,322)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,386,892	44
45	Private Pay - Net Inpatient Revenue	2,896,777	45
46	Medicare - Net Inpatient Revenue	987,011	46
47	Other-(specify) Insurance	474,195	47
48	Other-(specify) Hospice	309,077	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,053,952	49

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

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

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

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

Knox County Nursing Home
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	Other Current Assets:	Amount
28A	TRANS IN-TORT STOP LOSS	(116,177)
	TRANS IN -REFERENDUM	(531,117)
	Cap. Improv. Transfer	(41,811)
	FARM INCOME	-
	TRANS TO OTHER FUNDS	531,117
	CURRENT PROPERTY TAX	(743,833)
	UNANTICIPATED REVENUE	(793)
	Transfer to NH Fund	41,811
	Total	**(860,803)**

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

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	2,115	2,355	$ 96,007	$ 40.77	1
2	Assistant Director of Nursing	2,115	2,355	59,090	25.09	2
3	Registered Nurses	19,198	21,369	483,124	22.61	3
4	Licensed Practical Nurses	52,488	58,425	948,341	16.23	4
5	CNAs & Orderlies	165,396	167,985	2,391,735	14.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,561	1,938	43,399	22.39	9
10	Activity Assistants	7,037	8,733	68,455	7.84	10
11	Social Service Workers	9,119	9,885	120,363	12.18	11
12	Dietician					12
13	Food Service Supervisor	3,903	4,148	61,941	14.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,341	36,496	394,382	10.81	15
16	Dishwashers					16
17	Maintenance Workers	8,344	9,422	137,838	14.63	17
18	Housekeepers	22,199	24,262	257,395	10.61	18
19	Laundry	6,464	7,167	76,556	10.68	19
20	Administrator	2,080	2,280	73,653	32.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,695	13,841	195,864	14.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Barber & Beauty	1,692	1,819	27,036	14.86	33
34	TOTAL (lines 1 - 33)	350,747	372,480	$ 5,435,179 *	$ 14.59	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	295	$ 11,790	1-3	35
36	Medical Director	Monthly	9,000	9-3	36
37	Medical Records Consultant	Quarterly	2,083	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,461	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	Quarterly	659	10-3	47
48					48
49	TOTAL (lines 35 - 48)	295	$ 33,993		49

C. CONTRACT NURSES

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2015 Ending: 11/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Secrist	Administrator	0%	$ 73,653
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 73,653

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Davis & Campbell	Legal	$ 7,927
Knox County	Reimbursed IT	26,649
Wipfli	Audit	3,720
FGMK, LLC	Healthcare Consulting	9,800
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 48,096

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 204,452
Unemployment Compensation Insurance	32,370
FICA Taxes	463,121
Employee Health Insurance	933,789
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	567,264
Trans In-SS	(159,335)
Trans From IMRF	(318,670)
IMRF NPO	94,026
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,817,017

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$
Advertising: Employee Recruitment		386
Health Care Worker Background Check		
(Indicate # of checks performed	67)	1,736
Patient Background Checks	116	1,160
Pre-Employment Testing		29,120
Dues & Subscriptions		1,330
Marketing Services		6,232
Less: Public Relations Expense		(6,232)
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 33,732

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,102
Seminar Expense	2,973
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,075

**See instructions.

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Page 21- Supplemental -Seminar Expense
12/1/2015-11/30/2016

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	
42353	CARL SANDBURG COLLEGE	FOOD SAFETY	13 @ 9.99 EACH	DIETARY	GALESBURG IL	130	
42452	IL COUNCIL ON	FACILITY ABUE PREVENTION	RACHEL	ADMIN.	CHICAGO IL	50	
42452	IL NURSING HOME	IL NURSING ADMIN./NURSING	RACHEL/TAMMY GUILE	ADMIN./DON	PEORIA IL	190	
42908	IL NURSING HOME	LONG TERM CARE	RACHEL /LEANNE	ADMIN./CARE PLAN	BLOOMINGTON IL	190	
42641	EASTERN IOWA	ACTIVITY	WHITNEY GREEN	MEMORY CARE CORR	IOWA DAVENPORT	50	
42697	IL NURSING HOME	ADMINISTRATOR'S ASS	RACHEL/TGUIL/TLEAF/RON W	DEPT. HEAD	SPRINGFIELD IL	500	
42487	RAMIREZ CONSULTING	SOCIAL SERVICE/ACTIVITY	KEVIN/TAMMIE LEAF	DEPT. HEAD	IN HOUSE	256	
						230	
			TRAINING	004.000.580560.55			
42629	SPOON RIVER ACT. ASS	WORKSHOP	TAMMIE LEAF	ACTIVITY COOR.	MACOMB IL	20	
42669	KOHL WHOLESALE	SERVSAFE TRAINING/EXAM	CORY HUDDLESTON	DIETARY MANAGER	KNOXVILLE IL	260	
	CLASSIC ACCENTS	NAME TAG	EMPLOYEES		IN HOUSE	677	R
	PETTY CASH	EMPLOYEE INSENTIVE	EMPLOYEES		IN HOUSE	250	R
	OFFICE SPECIALIST	HR/SUPPLIES	EMPLOYEES		IN HOUSE	303	R
	WESCOM SOLUTION	POINTCLICK CARE / HER	EMPLOYEES		IN HOUSE	150	
	PROFESSIONAL MEDICAL	ONLINE TRAINING	EMPLOYEES		IN HOUSE	896	
	AMSTERDAM	HR/SUPPLIES	EMPLOYEES		IN HOUSE	418	R
42452	CHANNING BETE	CPR TRAINING	TAMMY GUILE	DON	INSTRUC. MANUAL	136	
42599	CHAMBER OF COMMERCE	LEGISTATOR' LUNCHEON	RACHEL/MEG	ADMIN/ADMIN ASS	GALESBURG IL	20	R
42424	AANAC	MEMBERSHIP RENEWAL	ANGIE WHITMAN	ANGIE WHITMAN	IN HOUSE	119	R
42487	CARL SANDBURG COLLEGE	FOOD SAN. MANAGER CERT.	CORY HUDDLESTON	CORY HUDDLESTON	GALESBURG IL	145	
						4,990	
						(1,787)	Reclassified
						(230)	Undocumented
					Total	**2,973**	

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Page 21- Supplemental -Legal Expense
12/1/2015-11/30/2016

Date	G/L Acct	Payee Vendor	Service	Amount
7/27/2016	004.000.560260.55	DAVIS & CAMPBELL	Legal	145
9/28/2016	004.000.560260.55	DAVIS & CAMPBELL	Legal	218
10/26/2016	004.000.560260.55	DAVIS & CAMPBELL	Legal	73
10/26/2016	004.000.560260.55	DAVIS & CAMPBELL	Legal	73
11/23/2016	004.000.560260.55	DAVIS & CAMPBELL	Legal	2,683
11/23/2016	004.000.560260.55	DAVIS & CAMPBELL	Legal	4,737
			Total	**7,927**

Knox County Nursing Home
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Page 21- Supplemental -Travel Expense
12/1/2015-11/30/2016

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	FOOD	AIRFARE	HOTEL	TOTAL
6/22/2016	RACHEL SECRIST	ADMINISTRATOR	BLOOMINGTON	CONFERENCE		MILEAGE		94
8/24/2016	RACHEL SECRIST	ADMINISTRATOR/DON	NAPERVILLE	CONFERENCE			MARRIOTT	156
8/24/2016	RACHEL SECRIST	ADMINISTRATOR/DON	NAPERVILLE	CONFERENCE		TOLL FEE		17
8/24/2016	TAMMY GUILE	DON	NAPERVILLE	CONFERENCE		MILEAGE		193
8/24/2016	RACHEL SECRIST	ADMINISTRATOR/CON	NAPERVILLE	CONFERENCE	OLD TOWN			55
8/24/2016	RACHEL SECRIST	ADMINISTRATOR/DON	DEKALB	CONFERENCE	SUBWAY			26
11/23/2016	RACHEL SECRIST	ADMINISTRATOR/DON	SPRINGFIELD	CONFERENCE	OUTBACK			36
11/23/2016	RACHEL SECRIST	ADMINISTRATOR/DON	SPRINGFIELD	CONFERENCE			HOTEL	106
11/23/2016	TAMMY GUILE	DON	BLOOMINGTON	CONFERENCE		MILEAGE		123
11/23/2016	DONNA MOTZ	ADON	BLOOMINGTON	CONFERENCE		MILEAGE		46
Various	Various	Various	Various	FUEL EXPENSE				201
Various	Various	Various	Various	NH Ref. Travel				3,049
							Total	**4,102**

Knox County Nursing Home
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Other Administrative Staff Transportation Schedule
12/1/2015-11/30/2016

Date	Employee Name	Reference	Amount
Various	Nursing Home Committee Members	Per Diem/Mileage	2456
		Total	**2456**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **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? **5 Year**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **35,183** 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. $ **372,870**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ ____ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **15,694**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ ____
c. What percent of all travel expense relates to transportation of nurses and patients? **Ln 14**
d. Have vehicle usage logs been maintained? ____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **WipFli**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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