

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: 0021832 Facility Name: A Merkle C Knipprath Nursing Home Address: 1190 E 2900 North Road Clifton 60927-9705 County: Iroquois Telephone Number: (815) 694-2306 Fax #: (815) 694-2818 HFS ID Number: Date of Initial License for Current Owners: 10/1/1975 Type of Ownership: X VOLUNTARY,NON-PROFIT X Charitable Corp. Trust IRS Exemption Code 501(c)(3) PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Brother Damien Telephone Number: (815) 694-2306 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 1/1/2011 to 12/31/2011 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) (Type or Print Name) Brother Damien (Title) Executive Director Paid Preparer (Signed) (Print Name and Title) Michael Stroud Shareholder (Firm Name & Address) Smith, Koelling, Dykstra & Ohm, P.C. 1605 N Convent, Bourbonnais, IL 60914 (Telephone) (815) 937-1997 Fax #: (815) 935-0360 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
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Facility Name & ID Number A Merkle C Knipprath Nursing Home

#	0021832	Report Period Beginning:	1/1/2011	Ending:	12/31/2011
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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

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

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

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 10/6/1975

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 99 and days of care provided

Medicare Intermediary Administrator Federal

IV. ACCOUNTING BASIS

ACCUAL	X	MODIFIED CASH*		CASH*	
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/11 **Fiscal Year:** 12/31/11

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

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		Sheltered Care (SC)			5		
6		ICF/DD 16 or Less			6		
7	99	TOTALS	99	36,135	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			2,282	2,282	8
9	SNF/PED					9
10	ICF	7,326	5,672		12,998	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,326	5,672	2,282	15,280	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 42.29%

Facility Name & ID Number A Merkle C Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2011 Ending: 12/31/2011
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	243,897	13,216	13,364	270,477		270,477		270,477			1
2	Food Purchase		122,757		122,757	(21,162)	101,595	(8,965)	92,630			2
3	Housekeeping	81,745	6,874	508	89,127		89,127	(12,605)	76,522			3
4	Laundry	29,411	1,553	3,940	34,904		34,904		34,904			4
5	Heat and Other Utilities			153,796	153,796	(2,378)	151,418	(29,467)	121,951			5
6	Maintenance	80,355	1,347	18,122	99,824		99,824	(18,736)	81,088			6
7	Other (specify):* ILU Expense			1,002	1,002		1,002	(1,002)				7
8	TOTAL General Services	435,408	145,747	190,732	771,887	(23,540)	748,347	(70,775)	677,572			8
	B. Health Care and Programs											
9	Medical Director			5,700	5,700		5,700		5,700			9
10	Nursing and Medical Records	987,806	60,526	8,791	1,057,123		1,057,123	(13,500)	1,043,623			10
10a	Therapy	16,458		543	17,001		17,001		17,001			10a
11	Activities	58,450	10,202	3,844	72,496		72,496	(4,509)	67,987			11
12	Social Services	15,918			15,918		15,918		15,918			12
13	CNA Training											13
14	Program Transportation			1,039	1,039		1,039		1,039			14
15	Other (specify):* Cost of Sundries			4,400	4,400		4,400	(4,400)				15
16	TOTAL Health Care and Programs	1,078,632	70,728	24,317	1,173,677		1,173,677	(22,409)	1,151,268			16
	C. General Administration											
17	Administrative	80,004			80,004	5,614	85,618	(20,614)	65,004			17
18	Directors Fees											18
19	Professional Services			30,359	30,359		30,359		30,359			19
20	Dues, Fees, Subscriptions & Promotions			4,506	4,506		4,506		4,506			20
21	Clerical & General Office Expenses	111,179	4,403	7,358	122,940		122,940		122,940			21
22	Employee Benefits & Payroll Taxes			501,962	501,962	21,162	523,124	(10,151)	512,973			22
23	Inservice Training & Education			451	451		451		451			23
24	Travel and Seminar			248	248		248		248			24
25	Other Admin. Staff Transportation			616	616		616		616			25
26	Insurance-Prop.Liab.Malpractice			31,716	31,716	(265)	31,451	(2,787)	28,664			26
27	Other (specify):*			34,595	34,595		34,595	(34,595)				27
28	TOTAL General Administration	191,183	4,403	611,811	807,397	26,511	833,908	(68,147)	765,761			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,705,223	220,878	826,860	2,752,961	2,971	2,755,932	(161,331)	2,594,601			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		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			205,964	205,964	(2,971)	202,993	(84,476)	118,517			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											35
36	Other (specify):*											36
37	TOTAL Ownership			205,964	205,964	(2,971)	202,993	(84,476)	118,517			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			306,933	306,933		306,933		306,933			39
40	Barber and Beauty Shops			8,934	8,934		8,934	(8,786)	148			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			370,070	370,070		370,070	(8,786)	361,284			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,705,223	220,878	1,402,894	3,328,995		3,328,995	(254,593)	3,074,402			45

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

Arthur Merkle Clara Knipprath Nursing Home
ID# #21832
Report Period 1/1/11 to 12/31/11
Schedule V Attachment - Reclassification

Food Purchase	Line 2, Col 5	(\$21,162)
Employee Benefits and Payroll Taxes (To reclassify employee meals)	Line 22, Col 5	21,162
Heat & Other Utilities	Line 5, Col 5	(2,378)
Maintenance	Line 6, Col 5	0
Insurance, Property and Liability	Line 26, Col 5	(265)
Depreciation	Line 30, Col 5	(2,971)
Administrative (To reclassify administrative costs for Brothers' residence)	Line 17, Col 5	<u>5,614</u>
Total Reclassification	Line 45, Col 5	<u><u>\$0</u></u>

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	(4,988)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,509)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,595)	27		24
25	Fund Raising, Advertising and Promotional				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	(210,501)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (254,593)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (254,593)		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

STATE OF ILLINOIS
A Merkle C Knipprath Nursing Home

	ID#	0021832
Report Period Beginning:		1/1/2011
Ending:		12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Independent Living Unit - Maintenace Wages	\$ (10,000)	6	1
2	Independent Living Unit Wages	(13,500)	10	2
3	Independent Living Unit Wages - Administration	(15,000)	17	3
4	Independent Living Unit Employee Benefits	(10,151)	22	4
5	Independent Living Unit Wages	(12,605)	3	5
6	Independent Living Unit Insurance	(2,787)	26	6
7	Independent Living Unit Depreciation	(84,476)	30	7
8	Independent Living Unit Utilities	(29,467)	5	8
9	Independent Living Unit Supplies	(91)	6	9
10	Independent Living Unit Maintenace & Other	(8,645)	6	10
11	Independent Living Unit Food Cost	(3,977)	2	11
12	Administration cost for Brothers' Residence	(5,614)	17	12
13	Adjust Barber & Beauty Due to Income Received	(8,786)	40	13
14	Adj Sundried Due to Income Received	(4,400)	15	14
15	Independent Living Unit - Other	(1,002)	7	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	(210,501)		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[illegible]

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
Franciscan Missionary Brothers of the Sacred Heart of Jesus	100%	N/A				

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			\$			\$	\$	1
2	V								2
3	V								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			\$			\$	\$ *	14

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

Facility Name & ID Number A Merkle C Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	Bro Damien Dabraekeleer	Executive Director	Administrator	0.00		46	100.00	Stipend to	\$ 80,004	17	1
2	Bro William Farrelly	Director	Nursing	0.00		44	100.00	Religious	70,500	10	2
3	Bro Joseph Ruscha	Director	Maintenance	0.00		44	100.00	Order	52,996	6	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 203,500		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 Nursing Home # 0021832 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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					\$	\$		\$	25

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	None						\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	None												6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10	None												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. \$ _____ 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 2010 report.		\$	Tax Exempt	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).		\$	#VALUE!	3	
4. Real Estate Tax accrual used for 2011 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.		\$	#VALUE!	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007		9	
		2008		10	
		2009		11	
		2010		12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010 \$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>A Merkle C Knipprath Nursing Home</u>	COUNTY	<u>Iroquois</u>
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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 2010 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 2010.

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

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 BrickFrame MasonryNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
Countryside Villas, 15 Independent Living Units - 17,005 Square Feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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	SNF	1,730,560	1975	\$ 24,225	1
2	Farm/ILU	995,072	1975	32,775	2
3	TOTALS	2,725,632		\$ 57,000	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1975	1975	\$ 773,471	\$ 14,056		\$ 14,056	\$	724,275	4
5			1975	1975	432,948	1,763		1,763		426,777	5
6											6
7											7
8											8
	Improvement Type**										
9	Fixed Equipment			1981	924					924	9
10				1983	5,462	22	17	22		5,429	10
11				1984	4,868		15			4,868	11
12				1985	6,098		15			6,098	12
13				1987	6,773		25			6,773	13
14				1988	650					650	14
15				1989	2,032					2,032	15
16				1990	12,971					12,971	16
17				1991	9,327	161		161		8,923	17
18				1992	1,276					1,276	18
19				1993	25,219	616		616		25,219	19
20				1994	6,594					6,594	20
21				1995	2,825					2,825	21
22				1996	97,366	3,864		3,864		66,208	22
23	Fire Suppression System			1996	2,115	106		106		1,639	23
24	Formica Nuses Station			1996	5,395	180		180		5,395	24
25	PVC Vertical Blinds			1996	350					350	25
26	Heat Pump Compressor			1996	1,890					1,890	26
27	Therapy Room Cubicle			1996	321					321	27
28	Kitchen Heat Pump			1996	1,679					1,679	28
29	2 Water Heaters			1996	4,158	139		139		4,158	29
30	Call Light System			1996	1,348	45		45		1,348	30
31	Room Heaters			1996	3,603					3,603	31
32	Pump Generator Impr			1997	2,540					2,540	32
33	Fire Alarm Impr			1997	1,105					1,105	33
34	Fire Safety Code Impr			1997	5,844	390		390		5,650	34
35	Procure Nurse Call System			1997	36,033	2,402	15	2,402		34,832	35
36	Garbage Disposal			1998	1,142	76	15	76		1,028	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 Nursing Home

0021832

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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

1	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 Heat Pump	1998	\$ 2,853	\$	10	\$	\$	\$ 2,853	37
38 Fire Door	1998	200	10	20	10		135	38
39 Room Heat/Cool Unit	1998	3,632		10			3,632	39
40 Generator	1998	141,059	7,053	20	7,053		95,215	40
41 Cubicle Curtains	1998	5,250		10			5,250	41
42 Register Covers	1999	1,056		10			1,056	42
43 Walk-in Freezer/cooler	1999	20,126	805	25	805		10,063	43
44 Water Heater Booster	1999	1,131		10			1,131	44
45 Above Ground Tank	1999	1,495		10			1,495	45
46 Air/Heat Unit	1999	1,057		5			1,057	46
47 Air Return Extension	2000	1,532	102	15	102		1,174	47
48 SS Garbage Disposal	2000	527	26	20	26		303	48
49 (2) Air/Heat Units	2000	1,950		5			1,950	49
50 Resident Security System	2001	4,830	242	10	242		4,830	50
51 Sewage Component Impr	2001	4,549	303	15	303		3,185	51
52 Disposal	2001	549	27	10	27		549	52
53 Dehumidifier	2001	1,050	53	10	53		1,050	53
54 Chapel Heating/Cooling	2001	19,000	950	10	950		19,000	54
55 Natural Gas Hot Water Conversion	2002	29,705	1,980	15	1,980		18,813	55
56 Resident Hall Water Coolers	2002	1,657	166	10	166		1,574	56
57 Sewer Lagoon Impr	2002	6,824	682	10	682		6,483	57
58 Time Clock	2002	395	40	10	40		375	58
59 Resident Room Heat/Cool Unit	2003	3,470	231	15	231		1,966	59
60 Satellite	2003	782		5			782	60
61 Front Entrance Door	2003	3,612	361	10	361		3,070	61
62 Exterior Security Locks	2003	612	61	10	61		520	62
63 Closet Doors	2003	2,845	190	15	190		1,612	63
64 DR Rooftop Heating Unit	2003	6,325	422	15	422		3,584	64
65 Staff DR Cooling Unit	2003	2,600	173	15	173		1,473	65
66 Oxygen Room Ventilation	2004	593	59	10	59		445	66
67 Hot Water Supply - Mary Hall	2004	3,578	179	20	179		1,342	67
68 Water Softner System	2005	9,899	990	10	990		6,434	68
69 New Shower Valves, All Halls	2005	3,084	154	20	154		1,002	69
70 TOTAL (lines 4 thru 69)		\$ 1,744,154	\$ 39,079		\$ 39,079	\$	\$ 1,570,783	70

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

Facility Name & ID Number A Merkle C Knipprath Nursing Home

0021832

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	
1	Totals from Page 12A, Carried Forward		\$ 1,744,154	\$ 39,079		\$ 39,079	\$	\$ 1,570,783	1
2	Oxygen Room Sprinkler	2005	709	35	20	35		230	2
3	Water System Improvement	2005	1,241	124	10	124		807	3
4	Dishwasher Motor	2005	1,825		5			1,825	4
5	Heater Unit	2005	410	41	10	41		266	5
6	Well Pump Electrical	2005	1,518	101	15	101		658	6
7	Ice Machine	2007	6,265	627	10	627		2,819	7
8	Dishwasher Booster Heater	2007	1,225	245	5	245		1,103	8
9	Pump for Diesel Tank	2007	401	27	15	27		120	9
10	Chapel Heating & Cooling	2007	16,558	1,656	10	1,656		7,451	10
11	Central Nurse St Rooftop Unit	2007	16,861	1,124	15	1,124		5,058	11
12	Smoke Detector Upgrade	2007	2,820	141	20	141		635	12
13	Hot Water Heater Rebuild	2008	2,685	268	10	268		940	13
14									14
15	Land Improvements	1975	194,467	2,899		2,899		184,319	15
16		1979	8,614		25			8,614	16
17		1982	39,700		20			39,700	17
18		1983	1,999		11			1,999	18
19		1984	3,405		20			3,405	19
20		1985	860		20			860	20
21		1986	6,156		12			6,156	21
22		1992	6,346	317	20	317		6,187	22
23		1993	3,640		5			3,640	23
24		1995	6,753	113	5	113		6,357	24
25	Drive Pavement	1997	8,900	593	15	593		8,604	25
26	Well	1998	7,339	367	15	367		4,954	26
27	Sewer Improvement	1999	13,399		5			13,399	27
28	Drive Sealing	2000	8,945		15			8,945	28
29	Landscaping	2002	4,211	281	5	281		2,667	29
30	Drive Widening	2002	32,150	3,215	5	3,215		30,543	30
31	Sewage System Control Panel	2003	2,635	264	15	264		2,240	31
32	Water Well Improvement	2003	7,449	745	10	745		6,332	32
33	Drive Sealing	2004	3,996		10			3,996	33
34	TOTAL (lines 1 thru 33)		\$ 2,157,636	\$ 52,262		\$ 52,262	\$	\$ 1,935,612	34

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

Facility Name & ID Number A Merkle C Knipprath Nursing Home

0021832

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,157,636	\$ 52,262		\$ 52,262	\$	\$ 1,935,612	1
2	Sidewalk	2005	2,268	151	10	151		983	2
3	Landscaping	2007	2,362	157	15	157		708	3
4	Asphalt Repair/Replacement/Sealcoat	2008	8,665	866	10	866		3,033	4
5	Parking Lot Light System	2008	5,578	372	15	372		1,301	5
6	Asphalt Repair/Replacement/Sealcoat	2009	9,798	980	10	980		2,450	6
7									7
8	Buildings	1980	4,422		20			4,422	8
9		1981	1,738		10			1,738	9
10		1982	1,106		25			1,106	10
11		1984	130,023		20			130,023	11
12		1985	598		15			598	12
13		1986	640,838	13,307	33	13,307		510,208	13
14	Buildings	1987	37,528		15			37,528	14
15		1988	13,228		15			13,228	15
16		1989	10,488		15			10,488	16
17		1990	2,096		10			2,096	17
18		1991	35,542	832	20	832		35,542	18
19		1992	(34,187)	(854)	40	(854)		(15,995)	19
20		1993	475		10			475	20
21	Floor Tile Nurse Station	1996	2,050	68	15	68		2,050	21
22	Floor Tile Clara Wing	1996	778	26	15	26		778	22
23	Floor Tile, Main, Kitchen	1997	14,739		7			14,739	23
24	Hallway Impr	1997	3,870		5			3,870	24
25	Roof Improvements	1997	13,828	922	15	922		13,367	25
26	Floor Tile Arthur Wing	1998	6,475		10			6,475	26
27	DR Vinyl Floor	1998	4,420		5			4,420	27
28	Interior Corridor Doors	2000	2,415	161	10	161		1,852	28
29	Chapel Roof (Partial)	2001	3,099	207	15	207		2,169	29
30	Kitchen Doors	2001	1,031	52	20	52		1,031	30
31	New Roof	2002	32,319	1,616	20	1,616		15,352	31
32	Floor Tile	2002	2,919	195	15	195		1,849	32
33	Maintenance Shed	2002	7,010	280	25	280		2,664	33
34	TOTAL (lines 1 thru 33)		\$ 3,125,155	\$ 71,600		\$ 71,600	\$	\$ 2,746,160	34

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

Facility Name & ID Number A Merkle C Knipprath Nursing Home

0021832

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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	
1	Totals from Page 12C, Carried Forward		\$ 3,125,155	\$ 71,600		\$ 71,600	\$	\$ 2,746,160	1
2	North Wing Roof	2003	34,539	1,727	20	1,727		14,679	2
3	Chapel Windows	2003	18,234	912	20	912		7,749	3
4	Resident Room Tiling	2003	1,521	152	10	152		1,293	4
5	Chapel Entry Flooring	2003	2,924	292	10	292		2,486	5
6	Chapel Roof/Glass	2004	3,115	208	15	208		1,558	6
7	Tiling Mary Hall	2004	36,035	3,604	10	3,604		27,026	7
8	Mary Hall Rehab	2004	7,660	511	15	511		3,830	8
9	Mary Hall Wiring	2004	3,050	153	20	153		1,144	9
10	Dining Area Painting	2005	1,875		5			1,875	10
11	Water Supply System Impr	2006	1,540	154	5	154		1,540	11
12	Fire Alarm System	2006	29,014	1,934	15	1,934		10,638	12
13	Kitchen Rooftop Unit	2006	10,078	672	15	672		3,695	13
14	Heater Units	2006	5,735	574	10	574		3,154	14
15	Nursing Sanitation Equipment	2006	705	71	10	71		388	15
16	Door Security System Upgrade	2006	3,123	312	10	312		1,718	16
17	Lot Sealing	2006	3,211	321	5	321		3,211	17
18	Life Safety Improvements	2006	4,054	405	5	405		4,054	18
19	Chapel Roof	2006	11,986	799	15	799		4,395	19
20	Chapel Drywall/Paint	2006	6,941	694	10	694		3,818	20
21	Gutters	2006	256	17	15	17		94	21
22	Chapel fire Rated Doors	2007	3,954	158	25	158		712	22
23	Life Safety Electric Upgrade	2007	824	41	20	41		185	23
24	Andrew Hall Electric Upgrade	2007	2,715	136	20	136		611	24
25	Mary Wing Roofing	2007	21,900	1,460	15	1,460		6,570	25
26	Flooring	2008	37,045	3,705	10	3,705		12,966	26
27	Main Building Roofing	2008	66,500	3,325	20	3,325		11,638	27
28	Andrew & Arthur Hall Roofing	2009	10,500	525	20	525		1,313	28
29	Mary Hall Roofing	2009	28,875	1,444	20	1,444		3,609	29
30	Clara Hall Roofing	2009	34,804	1,740	20	1,740		4,351	30
31	5 - Room Furn & AC Units	2010	5,690	569	10	569		711	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,523,558	\$ 98,215		\$ 98,215	\$	\$ 2,887,171	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$250,433	\$19,758	\$19,758	\$		\$203,065	71
72	Current Year Purchases	8,914	613	613			613	72
73	Fully Depreciated Assets	265,740					265,740	73
74								74
75	TOTALS	\$525,087	\$20,371	\$20,371	\$		\$469,418	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	1996 FORD ELDORADO TRANSIT BUS		1996	\$38,099	\$	\$		10	\$38,099	76
77	1996 MERCURY SABLE		1996	15,878				4	15,878	77
78	1993 MERCURY VILLAGER		1992	18,387				5	18,387	78
79	1997 GMC TRUCK		2002	14,580				7	14,580	79
80	TOTALS			\$86,944	\$	\$			\$86,944	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)	\$4,192,589	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$118,586	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$118,586	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,443,533	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	BROTHER RESIDENCE	\$95,606	\$2,449	\$87,033	86
87	BROTHER RESIDENCE EQUIPMENT	22,663	522	19,697	87
88	APARTMENT COMPLEX BLDG	1,804,851	54,320	1,038,164	88
89	APARTMENT COMPLEX EQUIPMEN	734,679	28,363	640,903	89
90	APARTMENT COMPLEX LAND IMP	29,283	1,727	26,100	90
91	TOTALS	\$2,687,082	\$87,381	\$1,811,897	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.

Arthur Merkle Clara Knipprath Nursing Home
ID# 21832
Report Period Beginning 1/1/11 to 12/31/11
Attachment to Schedule XI, Page 12C, Line 16

The Nursing Home received an adjustment on building improvements constructed in 1982 due to construction problems relating to leakage in the chapel roof. This amount is reflected as a 1992 line item and adjusted prospectively.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:NA
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

**

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: \$ Description:

(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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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

☒ 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

☐

☐

All new nurses aids are required to have completed the proper certification and training prior to being hired.

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.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			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		hrs	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist	39-3	hrs				252,140		252,140	3
4	Licensed Physical Therapist		hrs							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 prescrpts				44,937		44,937	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):	39-3					9,856		9,856	12
13	Other (specify):									13
14	TOTAL			\$		\$	306,933		306,933	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 201,819	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,000)	616,439		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,955,494		5
6	Prepaid Insurance	30,971		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other AR and Accr Int	9,649		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,814,372	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	600,000		12
13	Land	479,128		13
14	Buildings, at Historical Cost	3,941,298		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,459,242		16
17	Accumulated Depreciation (book methods)	(5,255,424)		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):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,224,244	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,038,616	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 116,488	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,877		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,033		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	Apartment Rental Deposits	13,725		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 182,123	\$	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)	\$ 182,123	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,856,493	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,038,616	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,115,675	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,115,675	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(259,182)	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)	\$ (259,182)	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)	\$ 5,856,493	24

*

* This must agree with page 17, line 47.

Facility Name & ID Number A Merkle C Knipprath Nursing Home# 0021832Report Period Beginning: 1/1/2011Ending: 12/31/2011

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.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,975,530	1
2	Discounts and Allowances for all Levels	(1,169,606)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,805,924	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	14,845	14
15	Telephone, Television and Radio	36,169	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 51,014	23
	D. Non-Operating Revenue		
24	Contributions	25,271	24
25	Interest and Other Investment Income***	44,442	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 69,713	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Rental & Farm</u>	143,162	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 143,162	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,069,813	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	771,887	31
32	Health Care	1,173,677	32
33	General Administration	807,397	33
	B. Capital Expense		
34	Ownership	205,964	34
	C. Ancillary Expense		
35	Special Cost Centers	315,867	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,328,995	40
41	Income before Income Taxes (line 30 minus line 40)**	(259,182)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (259,182)	43

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

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

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	2,080	2,304	\$ 69,060	\$ 29.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,883	9,787	249,168	25.46	3
4	Licensed Practical Nurses	12,310	13,550	259,657	19.16	4
5	CNAs & Orderlies	35,374	37,854	402,414	10.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,690	1,690	16,458	9.74	8
9	Activity Director	2,042	2,298	29,922	13.02	9
10	Activity Assistants	2,335	2,631	28,528	10.84	10
11	Social Service Workers	734	846	15,918	18.82	11
12	Dietician					12
13	Food Service Supervisor	1,734	1,910	29,642	15.52	13
14	Head Cook	1,937	2,169	24,329	11.22	14
15	Cook Helpers/Assistants	15,965	17,629	189,925	10.77	15
16	Dishwashers					16
17	Maintenance Workers	4,280	4,464	80,355	18.00	17
18	Housekeepers	6,235	7,163	81,745	11.41	18
19	Laundry	2,701	2,701	29,411	10.89	19
20	Administrator	2,496	2,496	80,004	32.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,263	9,151	97,679	10.67	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	1,920	1,920	21,008	10.94	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	110,979	120,563	\$ 1,705,223 *	\$ 14.14	34

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	88	\$ 5,385	Ln 1, Col 3	35
36	Medical Director	36	5,700	Ln 9, Col3	36
37	Medical Records Consultant	12	720	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,822	Ln 10, Col 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	24	1,893	Ln 11, Col 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	256	\$ 16,520		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

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

** See instructions.

STATE OF ILLINOIS

0021832

Report Period Beginning:

1/1/2011

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Ending: 12/31/2011

Facility Name & ID Number

A Merkle C Knipprath Nursing Home

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Brother Damien	Administrator		\$ 80,004	Workers' Compensation Insurance	\$ 64,696	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	124,425	Health Care Worker Background Check		
				Employee Health Insurance	302,690	(Indicate # of checks performed)		
				Employee Meals	21,162	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Life Services Network	3,657	
						L1 Identity Solutions	252	
						MES/HPSO of IL	175	
						Catholic Health Assoc	130	
						Other	292	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 80,004			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 4,506		
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 512,973		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type	Amount					Out-of-State Travel	\$
Smith, Koelling, Dykstra & Ohm	Accounting & Audit	\$ 25,325						
Benefit Services Group	Fees	2,218						
WIPFLI	Fees	1,750						
IVANS	Medical Fees	805					In-State Travel	248
Check Crafters	Fees	130						
Latham Time Co	Fees	79						
Yellowbook	Fees	42						
Secretary of State	Fees	10					Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 30,359	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 248

* Attach copy of IMRF notifications

**See instructions.

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.
\$3,657 Life Services Network

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 30,158
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.

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES
NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 54,203

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.

\$ 21,162

Has any meal income been offset against related costs?

Yes

Indicate the amount.
\$ 4,988

(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?

67

d. Have vehicle usage logs been maintained?

Yes

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?

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.
\$

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:
Smith, Koelling, Dykstra & Ohm, P.C.

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

Yes

(19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.