FOR BHF USE

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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: 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) 374-0400
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 12/01/12 to 11/30/13 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
(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**

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/12 Ending: 11/30/13

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	169	Skilled (SNF)	169	61,685	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	169	TOTALS	169	61,685	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,397	16,660	6,603	49,660	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,397	16,660	6,603	49,660	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.51%

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 4,019

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: 12/01/12 Ending: 11/30/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	420,245	34,929	10,570	465,744		465,744		465,744			1
2	Food Purchase		336,035		336,035		336,035	(10,931)	325,104			2
3	Housekeeping	231,566	31,057		262,623		262,623		262,623			3
4	Laundry	70,898	16,729	88,572	176,199		176,199		176,199			4
5	Heat and Other Utilities			238,592	238,592		238,592		238,592			5
6	Maintenance	107,297	2,760	211,746	321,803		321,803	(87,672)	234,131			6
7	Other (specify):*											7
8	TOTAL General Services	830,006	421,510	549,480	1,800,996		1,800,996	(98,603)	1,702,393			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	3,876,721	206,299	10,955	4,093,975		4,093,975		4,093,975			10
10a	Therapy		2,685	100	2,785		2,785		2,785			10a
11	Activities	104,385	5,354	250	109,989		109,989		109,989			11
12	Social Services	133,231	762		133,993		133,993		133,993			12
13	CNA Training											13
14	Program Transportation			6,256	6,256		6,256		6,256			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,114,337	215,100	27,161	4,356,598		4,356,598		4,356,598			16
	C. General Administration											
17	Administrative	85,059		2,500	87,559		87,559		87,559			17
18	Directors Fees											18
19	Professional Services			33,786	33,786		33,786	(16,020)	17,766			19
20	Dues, Fees, Subscriptions & Promotions			41,810	41,810		41,810	(3,419)	38,391			20
21	Clerical & General Office Expenses	195,666	14,625	24,188	234,479		234,479	36,849	271,328			21
22	Employee Benefits & Payroll Taxes			1,549,662	1,549,662		1,549,662	431,897	1,981,559			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,031	9,031		9,031		9,031			24
25	Other Admin. Staff Transportation			2,515	2,515		2,515		2,515			25
26	Insurance-Prop.Liab.Malpractice			37,175	37,175		37,175		37,175			26
27	Other (specify):*											27
28	TOTAL General Administration	280,725	14,625	1,700,667	1,996,017		1,996,017	449,307	2,445,324			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,225,068	651,235	2,277,308	8,153,611		8,153,611	350,704	8,504,315			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Knox County Nursing Home #0010561 Report Period Beginning: 12/01/12 Ending: 11/30/13

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			275,874	275,874		275,874	14,730	290,604			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			660	660		660		660			35
36	Other (specify):*											36
37	**TOTAL Ownership**			276,534	276,534		276,534	14,730	291,264			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		167,297	583,864	751,161		751,161		751,161			39
40	Barber and Beauty Shops	24,681	1,132		25,813		25,813	(6,294)	19,519			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			452,593	452,593		452,593		452,593			42
43	Other (specify):* **Current Taxes**			1,058	1,058		1,058	(1,058)				43
44	**TOTAL Special Cost Centers**	24,681	168,429	1,037,515	1,230,625		1,230,625	(7,352)	1,223,273			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,249,749	819,664	3,591,357	9,660,770		9,660,770	358,082	10,018,852			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: 12/01/12 Ending: 11/30/13

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	(10,931)	02		4
5	Telephone, TV & Radio in Resident Rooms	(4,980)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,730	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	712	21		24
25	Fund Raising, Advertising and Promotional	(3,419)	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	(111,099)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (114,987)		$	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)	473,069		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 473,069		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 358,082		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: 12/01/12

Ending: 11/30/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (55)	21	1
2	Barber & Beauty	(6,294)	40	2
3	Current Farm Taxes	(1,058)	43	3
4	Capitalized R&M (Net)	(87,672)	06	4
5	Non-Allowable Legal	(16,020)	19	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(111,099)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nursing Home # 0010561 **Report Period Beginning:** 12/01/12 **Ending:** 11/30/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,931)	0	0	0	0	0	0	0	0	0	0	(10,931)	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	(87,672)	0	0	0	0	0	0	0	0	0	0	(87,672)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(98,603)	0	0	0	0	0	0	0	0	0	0	(98,603)	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	(16,020)	0	0	0	0	0	0	0	0	0	0	(16,020)	19
20	Fees, Subscriptions & Promotions	(3,419)	0	0	0	0	0	0	0	0	0	0	(3,419)	20
21	Clerical & General Office Expenses	(4,323)	41,172	0	0	0	0	0	0	0	0	0	36,849	21
22	Employee Benefits & Payroll Taxes	0	431,897	0	0	0	0	0	0	0	0	0	431,897	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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**	(23,762)	473,069	0	0	0	0	0	0	0	0	0	449,307	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(122,365)	473,069	0	0	0	0	0	0	0	0	0	350,704	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Knox County Nursing Home # 0010561 **Report Period Beginning:** 12/01/12 **Ending:** 11/30/13

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	14,730	0	0	0	0	0	0	0	0	0	0	14,730	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**	14,730	0	0	0	0	0	0	0	0	0	0	14,730	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	(6,294)	0	0	0	0	0	0	0	0	0	0	(6,294)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,058)	0	0	0	0	0	0	0	0	0	0	(1,058)	43
44	**TOTAL Special Cost Centers**	(7,352)	0	0	0	0	0	0	0	0	0	0	(7,352)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(114,987)	473,069	0	0	0	0	0	0	0	0	0	358,082	45

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/12 Ending: 11/30/13

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	IMRF - County	$	Knox County	100.00%	$ 316,210	$ 316,210	1
2	V	22	Payroll Taxes - County		Knox County	100.00%	115,687	115,687	2
3	V	21	Bookeeping & Accounting		Knox County	100.00%	41,172	41,172	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			$			$ 473,069	$ * 473,069	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: 12/01/12 Ending: 11/30/13

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/12 Ending: 11/30/13

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	County Board Members		Committee	0.00	None	Various		Per-Diem/	$		1
2								Mileage	2,515	25-3	2
3											3
4											4
5											5
6											6
7											7
8	Knox County holds committee meetings related to the nusring home.										8
9	Per-diems and mileage are paid separately by the nursing home.										9
10											10
11											11
12											12
13								TOTAL	$ 2,515		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: 12/01/12 Ending: 11/30/13

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 [ ]

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

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

	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	22	IMRF - County	Direct Cost	169		$ 316,210	$	169	$ 316,210	1
2	22	Payroll-County	Direct Cost	169		115,687		169	115,687	2
3	21	Bookeeping & Accounting	Direct Cost	169		41,172		169	41,172	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					$ 473,069	$		$ 473,069	25

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/12 Ending: 11/30/13

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												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: 12/01/12 Ending: 11/30/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2013 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:			
	2008		8
	2009		9
	2010		10
	2011		11
	2012		12

Facility is exempt from paying real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 2012 on the lines provided below. Enter only the portion of th cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/12 Ending: 11/30/13

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 Use	2 Square Feet	3 Year Acquired	4 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: 12/01/12 Ending: 11/30/13

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	$ 1,750,956	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1966	46,724		20	934	934	41,461	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	1,456	1,456	28,718	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	6,482	6,482	84,940	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	31,810	28
29	Various			1999	21,237		20	1,190	1,190	19,091	29
30	Various			2000	20,496		20			20,496	30
31	Various			2001	1,395		20	123	123	1,395	31
32	Various			2003	161,240		20	8,448	8,448	72,001	32
33	Various			2004	116,328		20	6,827	6,827	49,817	33
34	Various			2005	327,652		20	16,383	16,383	114,024	34
35	Various			2006	1,002,155		20	49,800	49,800	299,722	35
36	Various			2007	480,150		20	4,856		24,281	36

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

See Page 12A, Line 70 for total

**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: 12/01/12 Ending: 11/30/13

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	$ 37,370	37
38	Various	2009	386,135		20	12,487	12,487	61,214	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69	Financial Statement Depreciation			275,874			(275,874)		69
70	TOTAL (lines 4 thru 69)		$ 6,058,029	$ 275,874		$ 154,979	$ (125,751)	$ 3,727,025	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: 12/01/12 Ending: 11/30/13

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	
1	Totals from Page 12A, Carried Forward		$ 6,058,029	$ 275,874		$ 154,979	$ (120,895)	$ 3,727,025	1
2	Plumbing Repairs - Wing 4	2010	2,985			149	149	596	2
3	Pipe Repair - Wing 4	2010	4,214			211	211	844	3
4	Wing 4 Renovation- Plumbing, Tiling, Piping, Plumbing	2010	9,361			468	468	1,872	4
5	Oxygen Room Storage- Exhaust System, Vapor Seal Lighting	2010	4,547			227	227	908	5
6	Outside Lighting	2010	4,353			236	236	236	6
7	Replace Curbing & Sidewalks	2010	4,800			240	240	960	7
8	Basement Doors	2010	4,547			227	227	908	8
9	Trane RTU (Kitchen)	2011	12,980			595	595	595	9
10	Electrical Work Wing 2, 3, 4	2011	5,815			97	97	97	10
11	Wing 1 Renovation	2011	1,459,877			11,809	11,809	11,809	11
12	Outside Lighting	2011	5,066			21	21	21	12
13	Land Improvements	2012	4,999			250	250	417	13
14	Garbage Disposer	2012	2,318			232	232	300	14
15	Door Replacement	2012	4,245			212	212	318	15
16	Boiler Replacement	2012	161,125			8,056	8,056	11,413	16
17	Door Locks & Keypads	2012	3,329			166	166	208	17
18	Smoke Dampers	2012	8,458			423	423	458	18
19	Sidewalk Replacement	2013	4,900			82	82	82	19
20	Additional Boiler Project	2013	17,876			298	298	298	20
21	Gazebo Roof	2013	4,800			60	60	60	21
22	Ice Machine - (Plumbing Roughed-In)	2013	4,687			39	39	39	22
23	Garage Roof	2013	3,500			29	29	29	23
24	Flooring Office/Reception	2013	4,353			435	435	18	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,801,164	$ 275,874		$ 179,542	$ (96,332)	$ 3,759,512	34

**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: 12/01/12 Ending: 11/30/13

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	$ 1,789,650	$	$ 108,537	$ 108,537	10	$ 1,271,761	71
72	Current Year Purchases	59,094		2,525	2,525	10	2,525	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,848,744	$	$ 111,062	$ 111,062		$ 1,274,286	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 Wagon	1993	$ 10,827	$	$	$	5	$ 10,827	76
77		Ford Truck	1995	17,024				5	17,024	77
78		Van	2005	43,984				5	43,984	78
79		Van	2005	34,452				5	34,452	79
80	TOTALS			$ 106,287	$	$	$		$ 106,287	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)	$ 9,912,795	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 275,874	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 290,604	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,730	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,140,085	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/12 Ending: 11/30/13

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

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: ____ *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 660 Description: Postage Meter
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/12 Ending: 11/30/13

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.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/12 Ending: 11/30/13

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-03	hrs	$		$ 245,639	$		$ 245,639	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			57,351			57,351	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			280,874			280,874	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				132,801		132,801	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Oxygen/Supplies						34,496		34,496	13
14	TOTAL			$		$ 583,864	$ 167,297		$ 751,161	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: 12/01/12 Ending: 11/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/13 (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	$ 760,215	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,096,839		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): Property Tax Receivable	731,654		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,588,708	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,994,870		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	8,960,975		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(5,580,000)		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)**	$ 5,375,845	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,964,553	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 224,246	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	382,881		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	25,817		36
37	Deferred Property Taxes	723,180		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,356,124	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,356,124	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,608,429	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,964,553	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,070,801	1
2	Restatements (describe):		2
3	**Audit Adjustments (Revenue & Expenses)**	(19,746)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,051,055	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(442,625)	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) **Rounding**	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (442,626)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,608,429	24 *

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

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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	$ 8,286,001	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,286,001	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,381	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 236,381	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	1,862	12
13	Barber and Beauty Care	6,294	13
14	Non-Patient Meals	10,931	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	80,260	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 99,347	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(147,390)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (147,390)	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Farm Income/Unanticipated Revenue**	36,221	28
28a	**Current Property Tax Revenue**	707,585	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 743,806	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,218,145	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,800,996	31
32	Health Care	4,356,598	32
33	General Administration	1,996,017	33
	B. Capital Expense		
34	Ownership	276,534	34
	C. Ancillary Expense		
35	Special Cost Centers	778,032	35
36	Provider Participation Fee	452,593	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,660,770	40
41	**Income before Income Taxes (line 30 minus line 40)****	(442,625)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (442,625)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,683,872	44
45	Private Pay - Net Inpatient Revenue	2,560,776	45
46	Medicare - Net Inpatient Revenue	1,744,710	46
47	Other-(specify) **Hospice**	239,204	47
48	Other-(specify) **Insurance**	57,439	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,286,001	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,510	2,753	$ 93,311	$ 33.89	1
2	Assistant Director of Nursing	1,461	1,780	57,430	32.26	2
3	Registered Nurses	16,399	18,527	469,559	25.34	3
4	Licensed Practical Nurses	41,637	20,231	921,713	45.56	4
5	CNAs & Orderlies	130,181	147,951	2,334,708	15.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,261	2,496	40,501	16.23	9
10	Activity Assistants	4,265	5,070	63,884	12.60	10
11	Social Service Workers	8,294	9,856	133,231	13.52	11
12	Dietician					12
13	Food Service Supervisor	3,163	3,827	57,043	14.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,724	33,468	363,202	10.85	15
16	Dishwashers					16
17	Maintenance Workers	4,576	5,355	107,297	20.04	17
18	Housekeepers	15,002	16,540	231,566	14.00	18
19	Laundry	6,551	7,464	70,898	9.50	19
20	Administrator	1,655	1,869	85,059	45.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,018	9,888	195,666	19.79	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	1,834	1,853	24,681	13.32	33
34	TOTAL (lines 1 - 33)	278,531	288,928	$ 5,249,749 *	$ 18.17	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	264	$ 10,570	1-3	35
36	Medical Director	Monthly	9,600	9-3	36
37	Medical Records Consultant	Quarterly	1,860	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,095	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	100	10A-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	250	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	266	$ 31,475		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathy Kopsack (12/1/2012-5/19/2013)	Administrator	0%	$ 47,367
Rachel Kehr (5/20/2013-12/31/13)	Administrator	0%	37,692
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,059

B. Administrative - Other

Description	Amount
Kathy Kopsack - Administrative Consultant	$ 2,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 2,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Davis & Campbell, LLC	Legal	$ 20,626
WIPFLI	Audit	3,660
FGMK, LLC	Accounting/Consulting	9,050
Unemployment Consulting	Unemployment Consulting	450
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 33,786

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 156,560
Unemployment Compensation Insurance	76,411
FICA Taxes	324,894
Employee Health Insurance	941,691
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	482,003
IMRF Transfer-In	(431,897)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,549,662

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	634
Health Care Worker Background Check	1,776
(Indicate # of checks performed 104)	
Patient Background Checks 110	1,866
Pre-Employment Screening	27,711
Dues & Subscriptions	575
Subscriptions	1,849
Marketing Services	3,419
Less: Public Relations Expense	( )
Non-allowable advertising	(3,419)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,391

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,047
Seminar Expense	5,984
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,031

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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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?
What was the average life used for new equipment added during this period? **10 Yr.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **42,621** 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. $ **452,593**
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. $ **10,931**

(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? **100 % Line 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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