FOR BHF USE

LL1

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

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0010561

Facility Name: Knox County Nurisng 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 12/01/13 to 11/30/2014 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 Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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	30,387	17,093	3,701	51,181	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,387	17,093	3,701	51,181	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.97%

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 08/28/1966

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 3,360

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 Nurisng Home # 0010561 **Report Period Beginning:** 12/01/13 **Ending:** 11/30/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	433,332	34,406	11,665	479,403		479,403		479,403			1
2	Food Purchase		353,733		353,733		353,733	(13,024)	340,709			2
3	Housekeeping	251,382	31,779		283,161		283,161		283,161			3
4	Laundry	77,383	21,364	109,952	208,699		208,699		208,699			4
5	Heat and Other Utilities			242,566	242,566		242,566		242,566			5
6	Maintenance	128,782	2,296	129,037	260,115		260,115	(48,776)	211,339			6
7	Other (specify):*											7
8	**TOTAL General Services**	890,879	443,578	493,220	1,827,677		1,827,677	(61,800)	1,765,877			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	4,004,741	193,562	13,948	4,212,251		4,212,251		4,212,251			10
10a	Therapy		1,603		1,603		1,603		1,603			10a
11	Activities	108,066	5,411	250	113,727		113,727		113,727			11
12	Social Services	91,141	593		91,734		91,734		91,734			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,203,948	201,169	23,798	4,428,915		4,428,915		4,428,915			16
	C. General Administration											
17	Administrative	71,099		54,145	125,244		125,244		125,244			17
18	Directors Fees											18
19	Professional Services			65,672	65,672		65,672		65,672			19
20	Dues, Fees, Subscriptions & Promotions			47,887	47,887		47,887	(11,620)	36,267			20
21	Clerical & General Office Expenses	175,811	59,795	27,106	262,712		262,712	(6,591)	256,121			21
22	Employee Benefits & Payroll Taxes			1,725,733	1,725,733		1,725,733	453,074	2,178,807			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,455	15,455		15,455		15,455			24
25	Other Admin. Staff Transportation			1,983	1,983		1,983		1,983			25
26	Insurance-Prop.Liab.Malpractice			24,048	24,048		24,048		24,048			26
27	Other (specify):*											27
28	**TOTAL General Administration**	246,910	59,795	1,962,029	2,268,734		2,268,734	434,863	2,703,597			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,341,737	704,542	2,479,047	8,525,326		8,525,326	373,063	8,898,389			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 Nurisng Home #0010561 **Report Period Beginning:** 12/01/13 **Ending:** 11/30/2014

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			274,206	274,206		274,206	(41,622)	232,584			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			912	912		912		912			35
36	Other (specify):*											36
37	**TOTAL Ownership**			275,118	275,118		275,118	(41,622)	233,496			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,766	586,924	696,690		696,690		696,690			39
40	Barber and Beauty Shops	25,652	1,072		26,724		26,724	(6,186)	20,538			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			404,609	404,609		404,609		404,609			42
43	Other (specify):* **Current Taxes**			1,192	1,192		1,192	(1,192)				43
44	**TOTAL Special Cost Centers**	25,652	110,838	992,725	1,129,215		1,129,215	(7,378)	1,121,837			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,367,389	815,380	3,746,890	9,929,659		9,929,659	324,063	10,253,722			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 Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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	(13,024)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,346)	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	(41,622)	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	(236)	21		24
25	Fund Raising, Advertising and Promotional	(11,620)	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	(56,163)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (129,011)		$	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)	453,074		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 453,074		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 324,063		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 Nurisng Home

ID# 0010561

Report Period Beginning: 12/01/13

Ending: 11/30/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber and Beauty	$ (6,186)	40	1
2	Bank Charges	(9)	21	2
3	Current Farm Taxes	(1,192)	43	3
4	Capitalized R&M	(48,776)	06	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(56,163)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nurisng Home # 0010561 **Report Period Beginning:** 12/01/13 **Ending:** 11/30/2014

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	(13,024)	0	0	0	0	0	0	0	0	0	0	(13,024)	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	(48,776)	0	0	0	0	0	0	0	0	0	0	(48,776)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(61,800)	0	0	0	0	0	0	0	0	0	0	(61,800)	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 Program**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(11,620)	0	0	0	0	0	0	0	0	0	0	(11,620)	20
21	Clerical & General Office Expenses	(6,591)	0	0	0	0	0	0	0	0	0	0	(6,591)	21
22	Employee Benefits & Payroll Taxes	0	453,074	0	0	0	0	0	0	0	0	0	453,074	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**	(18,211)	453,074	0	0	0	0	0	0	0	0	0	434,863	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(80,011)	453,074	0	0	0	0	0	0	0	0	0	373,063	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Knox County Nurisng Home # 0010561 **Report Period Beginning:** 12/01/13 **Ending:** 11/30/2014

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	(41,622)	0	0	0	0	0	0	0	0	0	0	(41,622)	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**	(41,622)	0	0	0	0	0	0	0	0	0	0	(41,622)	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	(6,186)	0	0	0	0	0	0	0	0	0	0	(6,186)	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):*	(1,192)	0	0	0	0	0	0	0	0	0	0	(1,192)	43
44	**TOTAL Special Cost Centers**	(7,378)	0	0	0	0	0	0	0	0	0	0	(7,378)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(129,011)	453,074	0	0	0	0	0	0	0	0	0	324,063	45

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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%	$ 188,279	$ 188,279	1
2	V	22	Payroll Taxes - County		Knox County	100.00%	264,795	264,795	2
3	V	19	Portion of IT Support	7,687	Knox County	100.00%	7,687		3
4	V	24	Travel	8,136	Knox County	100.00%	8,136		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			$ 15,823			$ 468,897	$ * 453,074	14

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

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Richard Conklin	BOD						1
2	Cheryl Nache	BOD						2
3	Lyle Johnson	BOD						3
4	Greg Bacon	BOD						4
5	Russell Nelson, Jr.	BOD						5
6	Robert Bondi	BOD						6
7	Barbara Foster	BOD						7
8	Pamela Davidson	BOD						8
9	Trisha Hurst	BOD						9
10	George Knapp	BOD						10
11	Shawn Pitman	BOD						11
12	David Erickson	BOD						12
13	Jeff Jefferson	BOD						13
14	Ricardo 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 Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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	1,983	25-03	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	$ 1,983		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 Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 1/30/2014

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		$ 188,279	$	169	$ 188,279	1
2	22	Payroll-County	Direct Cost	169		264,795		169	264,795	2
3	19	Portion of IT Support	Direct Cost	169		7,687		169	7,687	3
4	24	Travel	Direct Cost	169		8,136		169	8,136	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					$ 468,897	$		$ 468,897	25

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											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 Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:			
	2009		8
	2010		9
	2011		10
	2012		11
	2013		12

Facility is exempt from paying real estate taxes.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Knox County Nurisng 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 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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 Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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	$ 1,787,800	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1966	46,724		20	934	934	42,395	9
10	Various			1971	146,065		20				10
11	Various			1980	9,972		20				11
12	Various			1981	650		20				12
13	Various			1983	14,762		20				13
14	Various			1984	31,009		20				14
15	Various			1985	73,090		20				15
16	Various			1986	141,506		20				16
17	Various			1987	142,693		20				17
18	Various			1988	60,820		20				18
19	Various			1989	47,469		20				19
20	Various			1990	29,117		20	1,456	1,456	30,174	20
21	Various			1991	17,547		20				21
22	Various			1992	197,932		20				22
23	Various			1993	97,234		20	6,482	6,482	91,422	23
24	Various			1994	45,232		20				24
25	Various			1995	58,215		20				25
26	Various			1996	76,390		20				26
27	Various			1997	26,377		20				27
28	Various			1998	39,334		20	1,676	1,676	33,486	28
29	Various			1999	21,237		20	1,190	1,190	20,281	29
30	Various			2000	20,496		20				30
31	Various			2001	1,395		20	123	123	1,518	31
32	Various			2003	161,240		20	8,448	8,448	80,449	32
33	Various			2004	116,328		20	6,827	6,827	56,644	33
34	Various			2005	327,652		20	16,383	16,383	130,407	34
35	Various			2006	1,002,155		20	49,800	49,800	349,522	35
36	Various			2007	480,150		20	4,856	4,856	29,137	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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	$ 44,843	37
38	Various	2009	386,135		20	12,487	12,487	73,701	38
39	Various	2010	34,807		20	1,758	1,758	8,082	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	Book Depreciation			274,206			(274,206)		69
70	TOTAL (lines 4 thru 69)		$ 6,092,836	$ 274,206		$ 156,737	$ (117,469)	$ 2,779,861	70

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

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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		$ 6,092,836	$ 274,206		$ 156,737	$ (117,469)	$ 2,779,861	1
2	Trane RTU (Kitchen)	2011	12,980		20	595	595	1,190	2
3	Electrical Work Wing 2, 3, 4	2011	5,815		20	97	97	194	3
4	Wing 1 Renovation	2011	1,459,877		20	11,809	11,809	23,618	4
5	Outside Lighting	2011	5,066		20	21	21	42	5
6	Land Improvements	2012	4,999		20	250	250	667	6
7	Garbage Disposer	2012	2,318		20	232	232	532	7
8	Door Replacement	2012	4,245		20	212	212	552	8
9	Boiler Replacement	2012	161,125		20	8,056	8,056	11,588	9
10	Door Locks & Keypads	2012	3,329		20	166	166	643	10
11	Smoke Dampers	2012	8,458		20	423	423	1,681	11
12	Sidewalk Replacement	2013	4,900		20	245	245	327	12
13	Additional Boiler Project	2013	17,876		20	894	894	1,192	13
14	Gazebo Roof	2013	4,800		20	240	240	300	14
15	Ice Machine - (Plumbing Roughed-In)	2013	4,687		20	234	234	273	15
16	Garage Roof	2013	3,500		20	175	175	204	16
17	Flooring Office/Reception	2013	4,353		20	435	435	453	17
18	Parking Lot Rehab (Repairs, Sealcoating, remarking)	2014	58,684		20	978	978	978	18
19	Room 405 (Plumbing, Carpet, And Walls)	2014	20,438		20	596	596	596	19
20	Light Pole in Parking Lot	2014	5,013		20	146	146	146	20
21	Wing 2 Faucet Replacement	2014	4,456		20	130	130	130	21
22	Wing 4 Fire Door	2014	2,624		20	11	11	11	22
23	Sidewalk Replacement	2014	4,500		20	56	56	56	23
24	Kitchen Renovation (Flooring , Plumbing, Drywall, Lighting)	2014	84,258		20	351	351	351	24
25	Wings 1,2,3,4 Heating Units Replacement	2014	4,847		20	222	222	222	25
26	Wings 1,2,3,4 Heating Units Replacement	2014	20,138		20	1,007	1,007	1,007	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,006,122	$ 274,206		$ 184,319	$ (89,887)	$ 2,826,814	34

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

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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	$ 1,848,744	$	$ 47,086	$ 47,086	10	$ 1,314,943	71
72	Current Year Purchases	22,925		987	987	10	987	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,871,669	$	$ 48,073	$ 48,073		$ 1,315,930	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Ford Escort	1993	$ 10,827	$	$	$	5	$ 10,827	76
77		Ford Truck	1995	17,024				5	17,024	77
78		Van	2005	78,436				5	78,436	78
79		Truck Overhaul	2014	2,882		192	192	5	192	79
80	TOTALS			$ 109,169	$	$ 192	$ 192		$ 106,479	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,143,560	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 274,206	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 232,584	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (41,622)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,249,223	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 Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 912 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 Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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 Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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	$		$ 232,899	$		$ 232,899	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			75,919			75,919	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			274,610			274,610	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				96,950		96,950	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen/Supplies	39-02					12,816		12,816	12
13	Other (specify): Lab Services					3,496			3,496	13
14	TOTAL			$		$ 586,924	$ 109,766		$ 696,690	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.

STATE OF ILLINOIS

Facility Name & ID Number Knox County Nurisng Home **#** 0010561 **Report Period Beginning:** 12/01/13 **Ending:** 11/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2014 **(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	$ 651,081	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,849)	1,514,555		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 Rec.	741,962		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,907,598	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,554,461		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	9,142,848		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(5,854,206)		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)**	$ 4,843,103	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,750,701	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 175,913	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	470,539		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	731,500		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,403,769	$	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)**	$ 1,403,769	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,346,932	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,750,701	$	48

***(See instructions.)**

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,608,430	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,608,430	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(261,498)	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)**	$ (261,498)	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)**	$ 6,346,932	24 *

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

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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	$ 8,505,992	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,505,992	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	249,625	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 249,625	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,594	12
13	Barber and Beauty Care	6,186	13
14	Non-Patient Meals	13,024	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	29,846	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 52,650	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	140,059	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 140,059	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached	719,835	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 719,835	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,668,161	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,827,677	31
32	Health Care	4,428,915	32
33	General Administration	2,268,734	33
	B. Capital Expense		
34	Ownership	275,118	34
	C. Ancillary Expense		
35	Special Cost Centers	724,606	35
36	Provider Participation Fee	404,609	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,929,659	40
41	**Income before Income Taxes (line 30 minus line 40)****	(261,498)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (261,498)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,843,718	44
45	Private Pay - Net Inpatient Revenue	2,226,442	45
46	Medicare - Net Inpatient Revenue	1,724,483	46
47	Other-(specify) Hospice	375,364	47
48	Other-(specify) Insurance	335,985	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,505,992	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.**

	Other Current Assets	Amount
28A	TRANS IN-TORT STOP LOSS	(89,598.00)
	TRANS IN -REFERENDUM	(503,416.00)
	Cap. Improv. Transfer	(178,549.00)
	FARM INCOME	(16,137.00)
	TRANS TO OTHER FUNDS	100,000.00
	CURRENT PROPERTY TAX	(714,100.00)
	UNANTICIPATED REVENUE	-
	Transfer to NH Fund	178,549.00
	TRANS TO OTHER FUNDS	503,416.00
		(719,835.00)

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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	1,856	2,080	$ 69,925	$ 33.62	1
2	Assistant Director of Nursing	1,872	2,080	56,597	27.21	2
3	Registered Nurses	18,829	20,800	487,760	23.45	3
4	Licensed Practical Nurses	51,332	56,869	969,613	17.05	4
5	CNAs & Orderlies	157,771	178,388	2,420,846	13.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,870	2,080	34,486	16.58	9
10	Activity Assistants	7,899	9,376	73,580	7.85	10
11	Social Service Workers	8,419	9,537	91,141	9.56	11
12	Dietician					12
13	Food Service Supervisor	3,534	4,160	75,979	18.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,765	36,609	318,748	8.71	15
16	Dishwashers					16
17	Maintenance Workers	9,328	10,530	128,782	12.23	17
18	Housekeepers	14,473	17,505	251,382	14.36	18
19	Laundry	5,855	6,924	77,383	11.18	19
20	Administrator	1,807	2,080	71,099	34.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,803	20,145	229,956	11.42	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	1,731	1,818	25,652	14.11	33
34	TOTAL (lines 1 - 33)	337,144	380,981	$ 5,249,749 *	$ 13.78	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	292	$ 11,665	01-03	35
36	Medical Director	Monthly	9,600	09-03	36
37	Medical Records Consultant	Quarterly	960	10-03	37
38	Nurse Consultant	78	3,100	10-03	38
39	Pharmacist Consultant	Monthly	9,888	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	250	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	370	$ 35,463		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	40	$ 3,600	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	40	$ 3,600		53

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Secrist	Administrator	0	$ 71,099
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,099

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Davis and Campbell	Legal	$ 9,195
WIPFLI	Audit	8,060
FGMK, LLC	Accounting/ Consulting	8,750
CGS Administrators	Data Processing	1,492
PointClick Care	Computer Service	38,175
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 65,672

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 155,759
Unemployment Compensation Insurance	55,292
FICA Taxes	397,479
Employee Health Insurance	899,877
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	559,011
TRANS IN-SS	(188,279)
TRANS IN-IMRF	(264,795)
IMRF NPO	111,389
County Portion	453,074
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,178,807

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	$
Advertising: Employee Recruitment	1,574
Health Care Worker Background Check	
(Indicate # of checks performed 107)	2,139
Patient Background Checks 109	1,179
Dues and Subscriptions	667
Pre Employment Testing	30,036
Medical Publications	672
Marketing	11,620
Less: Public Relations Expense	( )
Non-allowable advertising	(11,620)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,267

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,249
Seminar Expense	6,206
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,455

* Attach copy of IMRF notifications

**See instructions.

Knox County
52589
Legal Schedule
12/01/2013-11/30/2014

Date	Vendor	Amount	ADJ	Allowable
1/31/2014	Davis & Campbell	276.25		276.25
1/31/2014	Davis & Campbell	6,468.50		6,468.50
3/31/2014	Davis & Campbell	350.00		350.00
3/31/2014	Davis & Campbell	2,100.00		2,100.00
		$ 9,194.75	$ -	$ 9,194.75

181513

Knox County
52589
Travel Schedule
12/01/2013-11/30/2014

Date	Vendor	Amount	ADJ	Allowable
	Robin Davis	8,136.00		8,136.00
	Herr Oil Prod. Ionc.	359.00		359.00
	Knox County	631.92		631.92
	Elan Corporate Payment Systems	122.08		122.08
		$ 9,249.00	$ -	$ 9,249.00

Knox County
52589
Seminar Schedule
12/01/2013-11/30/2014

Date	Payee	Topic	Attendee	Job Description	City/State	Amount	Adjusted	Allowable
12/23/2013	Classic Accents	New Employee Tags	All Staff		In House	60.5		60.5
1/29/2014	Amsterdam	Employee Folders	All Staff		In House	113.72		113.72
1/29/2014	Amsterdam	Employee Folders	All Staff		In House	262.27		262.27
1/29/2014	Classic Accents	New Employee Tags	All Staff		In House	22		22
2/26/2014	Classic Accents	New Employee Tags	All Staff		In House	22		22
3/26/2014	Classic Accents	New Employee Tags	All Staff		In House	55		55
3/26/2014	Classic Accents	New Employee Tags	All Staff		In House	34.01		34.01
3/26/2014	Ramirez	Consult with ACT & SS	K. Godsil/M. Meil/ T. Leaf	SS/Activity	In House	250		250
3/26/2014	Sun/ Staples Office Supply	Office Supply	Cathy Bowton	Hr	In House	28.42		28.42
4/23/2014	Classic Accents	New Employee Tags	All Staff		In House	77		77
4/23/2014	Illinois Nursing Home Assoc.	INHAA	Rachel/ Jori/ Tammy G	Training	East Peori	285		285
4/23/2014	Ramirez	Activity Program Training	Julie Jones	Training	East Peori	500		500
5/28/2014	Classic Accents	New Employee Tags	All Staff		In House	71.25		71.25
5/28/2014	Sun/ Staples Office Supply	Supplies For HR	Cathy Bowton	Training	In House	24.71		24.71
6/25/2014	Classic Accents	New Employee Tags	All Staff		In House	93.75		93.75
6/25/2014	Sun/ Staples Office Supply	Supplies For HR	Cathy Bowton	Human Resource	In House	45.16		45.16
7/23/2014	Classic Accents	New Employee Tags	All Staff		In House	38.5		38.5
7/23/2014	Professional Medical	Online Education	All Staff	All Staff	In House	895.95		895.95
7/23/2014	Ramirez	Consult with ACT & SS	K. Godsil/M. Meil/ T. Leaf	SS/Activity	In House	200		200
8/27/2014	Classic Accents	New Employee Tags	All Staff		In House	115.5		115.5
8/27/2014	Sun/ Staples Office Supply	Office Supply	Cathy Bowton	All Staff	In House	132.82		132.82
9/24/2014	Amsterdam	Employee Folders	All Staff	Training	In House	181.57		181.57
9/24/2014	Classic Accents	New Employee Tags	All Staff		In House	88		88
9/24/2014	Sun/ Staples Office Supply	Office Supply	Cathy Bowton		In House	15.34		15.34
10/29/2014	Classic Accents	New Employee Tags	All Staff	Training	In House	22		22
10/29/2014	Deb Inman	Clinical Training	Nursing Staff	All Staff	In House	480		480
10/29/2014	Monicare	Training Expense	Nursing Staff	Training	In House	908		908
10/29/2014	Ramirez	Consult with ACT & SS	K. Godsil/M. Meil/ T. Leaf	Training	In House	250		250
11/25/2014	Amsterdam	Employee Folders	Cathy Bowton	Training	In House	234.03		234.03
11/25/2014	Classic Accents	New Employee Tags	All Staff	Training	In House	49.5		49.5
11/25/2014	IMHAA Convention	Convention	Jori/Tammy/Rachel/Meg	Trade Show	Springfielc	500		500
11/25/2014	Ramirez	Consult with ACT & SS	K. Godsil/M. Meil/ T. Leaf	Training	In House	150		150
						$ 6,206.00	$ -	$ 6,206.00

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

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													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Knox County Nurisng Home # 0010561 Report Period Beginning: 12/01/13 Ending: 11/30/2014

XX. GENERAL INFORMATION:

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

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

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yr.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **43,822** 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. $ **404,609**
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. $ **13,024**

(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**
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Knox County
52589
Other Admin. Staff Transportation
12/01/2013-11/30/2014

Date	G/L Acct#	Employee Name	Reference	Amount
Various		Nursing Home Committee Members	Per Diems/Mileage	1,983.00

Related Party Allocation	
Total	1,983.00