FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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) 940-3269
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/2016 to 11/30/2017 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, Healthcare
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 374-0400 Fax # (847) 374-0420

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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			2,171	2,171	8
9	SNF/PED					9
10	ICF	24,902	21,031		45,933	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,902	21,031	2,171	48,104	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.98%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 1,686

Medicare Intermediary CGS Administrators

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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	454,803	27,406	9,575	491,784		491,784		491,784			1
2	Food Purchase		301,271		301,271		301,271	(14,661)	286,610			2
3	Housekeeping	245,247	27,278		272,525		272,525		272,525			3
4	Laundry	76,707	19,388	95,186	191,281		191,281		191,281			4
5	Heat and Other Utilities			231,576	231,576		231,576		231,576			5
6	Maintenance	143,401	2,747	259,730	405,878		405,878	(59,033)	346,845			6
7	Other (specify):*											7
8	TOTAL General Services	920,158	378,090	596,067	1,894,315		1,894,315	(73,694)	1,820,621			8
	B. Health Care and Programs											
9	Medical Director			9,750	9,750		9,750		9,750			9
10	Nursing and Medical Records	3,678,820	110,945	53,772	3,843,537		3,843,537		3,843,537			10
10a	Therapy		413		413		413		413			10a
11	Activities	94,969	5,888		100,857		100,857		100,857			11
12	Social Services	145,399	268		145,667		145,667		145,667			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,919,188	117,514	63,522	4,100,224		4,100,224		4,100,224			16
	C. General Administration											
17	Administrative	74,026			74,026		74,026		74,026			17
18	Directors Fees											18
19	Professional Services			51,535	51,535		51,535		51,535			19
20	Dues, Fees, Subscriptions & Promotions			42,186	42,186		42,186	(5,111)	37,075			20
21	Clerical & General Office Expenses	178,981	9,297	1,004,912	1,193,190		1,193,190	(950,375)	242,815			21
22	Employee Benefits & Payroll Taxes			2,279,012	2,279,012		2,279,012	337,669	2,616,681			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,747	7,747		7,747		7,747			24
25	Other Admin. Staff Transportation			1,770	1,770		1,770		1,770			25
26	Insurance-Prop.Liab.Malpractice			76,387	76,387		76,387		76,387			26
27	Other (specify):*											27
28	TOTAL General Administration	253,007	9,297	3,463,549	3,725,853		3,725,853	(617,817)	3,108,036			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,092,353	504,901	4,123,138	9,720,392		9,720,392	(691,511)	9,028,881			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: 12/1/2016 Ending: 11/30/2017

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			234,859	234,859		234,859	39,394	274,253			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			9,444	9,444		9,444		9,444			35
36	Other (specify):*											36
37	**TOTAL Ownership**			244,303	244,303		244,303	39,394	283,697			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		112,920	479,888	592,808		592,808		592,808			39
40	Barber and Beauty Shops	22,299	944		23,243		23,243	(4,138)	19,105			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			372,428	372,428		372,428		372,428			42
43	Other (specify):*			1,186	1,186		1,186	(1,186)				43
44	**TOTAL Special Cost Centers**	22,299	113,864	853,502	989,665		989,665	(5,324)	984,341			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,114,652	618,765	5,220,943	10,954,360		10,954,360	(657,441)	10,296,919			45

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,661)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,531)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	39,394	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	(950,361)	21		24
25	Fund Raising, Advertising and Promotional	(5,111)	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	(56,840)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (995,110)		$	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)	337,669		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 337,669		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (657,441)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Knox County Nursing Home

ID# 0010561

Report Period Beginning: 12/1/2016

Ending: 11/30/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beauty Revenue Offset	$ (4,138)	40	1
2	Non-Allowable Bank Charges	(14)	21	2
3	Non-Allowable County Farm Tax	(1,186)	43	3
4	Capitalized R&M	(51,502)	6	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**	(56,840)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nursing Home **#** 0010561 **Report Period Beginning:** 12/1/2016 **Ending:** 11/30/2017

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,661)	0	0	0	0	0	0	0	0	0	0	(14,661)	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	(59,033)	0	0	0	0	0	0	0	0	0	0	(59,033)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(73,694)	0	0	0	0	0	0	0	0	0	0	(73,694)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(5,111)	0	0	0	0	0	0	0	0	0	0	(5,111)	20
21	Clerical & General Office Expenses	(950,375)	0	0	0	0	0	0	0	0	0	0	(950,375)	21
22	Employee Benefits & Payroll Taxes	0	337,669	0	0	0	0	0	0	0	0	0	337,669	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**	(955,486)	337,669	0	0	0	0	0	0	0	0	0	(617,817)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,029,180)	337,669	0	0	0	0	0	0	0	0	0	(691,511)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Knox County Nursing Home # 0010561 **Report Period Beginning:** 12/1/2016 **Ending:** 11/30/2017

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	39,394	0	0	0	0	0	0	0	0	0	0	39,394	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**	39,394	0	0	0	0	0	0	0	0	0	0	39,394	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	(4,138)	0	0	0	0	0	0	0	0	0	0	(4,138)	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):*	(1,186)	0	0	0	0	0	0	0	0	0	0	(1,186)	43
44	**TOTAL Special Cost Centers**	(5,324)	0	0	0	0	0	0	0	0	0	0	(5,324)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(995,110)	337,669	0	0	0	0	0	0	0	0	0	(657,441)	45

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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	19	Portion of IT Support	$ 25,671	Knox County		$ 25,671	$	1
2	V	22	IMRF County		Knox County		225,113	225,113	2
3	V	22	Payroll Taxes County		Knox County		112,556	112,556	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			$ 25,671			$ 363,340	$ * 337,669	14

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

VII. RELATED PARTIES

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

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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	1,770	25-3	2
3											3
4											4
5											5
6											6
7											7
8	Knox County holds Committee Meetings related to the Nursing Home										8
9	Per Diems and Mileage are paid separately by the nursing home.										9
10											10
11											11
12											12
13								TOTAL	$ 1,770		13

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

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 1/30/2017

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	19	Portion of IT Support	Direct Cost	169		$ 25,671	$	169	$ 25,671	1
2	22	IMRF- County	Direct Cost	169		255,113		169	255,113	2
3	22	Payroll Tax-County	Direct Cost	169		112,556		169	112,556	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					$ 393,340	$		$ 393,340	25

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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

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

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Knox County Nursing Home # 0010561 **Report Period Beginning:** 12/1/2016 **Ending:** 11/30/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

Facility is exempt from paying real estate taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 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 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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	$ 156,000	1
2					2
3	TOTALS	1,481,040		$ 156,000	3

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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	$	$	$ 1,842,192	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1966	46,724		20	934	934	45,197	9
10	Various			1971	146,065		20			146,065	10
11	Various			1980	9,972		20			9,972	11
12	Various			1981	650		20			650	12
13	Various			1983	14,762		20			14,762	13
14	Various			1984	31,009		20			31,009	14
15	Various			1985	73,090		20			73,090	15
16	Various			1986	141,506		20			141,506	16
17	Various			1987	142,693		20			142,693	17
18	Various			1988	60,820		20			60,820	18
19	Various			1989	47,469		20			47,469	19
20	Various			1990	29,117		20			29,117	20
21	Various			1991	17,547		20			17,547	21
22	Various			1992	197,932		20			197,932	22
23	Various			1993	97,234		20			97,234	23
24	Various			1994	45,232		20			45,232	24
25	Various			1995	58,215		20			58,215	25
26	Various			1996	76,390		20			76,390	26
27	Various			1997	26,377		20			26,377	27
28	Various			1998	39,334		20	1,676	1,676	38,514	28
29	Various			1999	21,237		20			21,237	29
30	Various			2000	20,496		20			20,496	30
31	Various			2001	1,395		20			1,395	31
32	Various			2003	161,240		20	8,448	8,448	105,793	32
33	Various			2004	116,328		20	6,827	6,827	77,125	33
34	Various			2005	327,652		20	16,383	16,383	179,556	34
35	Various			2006	1,002,155		20	49,800	49,800	498,922	35
36	Various			2007	480,150		20	4,856	4,856	43,705	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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	$ 67,262	37
38	Various	2009	386,135		20	12,487	12,487	111,162	38
39	Various	2010	34,807		20	1,758	1,758	13,356	39
40	Various	2011	1,483,738		20	74,187	74,187	247,605	40
41	Various	2012	184,474		20	9,224	9,224	43,334	41
42	Various	2013	40,116		20	2,006	2,006	8,767	42
43	Parking Lot Rehab (Repairs, Sealcoating, remarking)	2014	58,684		20	2,934	2,934	9,780	43
44	Room 405 (Plumbing, Carpet, And Walls)	2014	20,438		20	1,022	1,022	3,662	44
45	Light Pole in Parking Lot	2014	5,013		20	251	251	899	45
46	Wing 2 Faucet Replacement	2014	4,456		20	223	223	799	46
47	Wing 4 Fire Door	2014	2,624		20	131	131	404	47
48	Sidewalk Replacement	2014	4,500		20	225	225	731	48
49	Kitchen Renovation (Flooring , Plumbing, Drywall, Lighting)	2014	84,258		20	4,213	4,213	12,990	49
50	Wings 1,2,3,4 Heating Units Replacement	2014	4,847		20	242	242	948	50
51	Wings 1,2,3,4 Heating Units Replacement	2014	20,138		20	1,007	1,007	4,028	51
52	Fire Door - Wing 4	2014	2,624		20	131	131	393	52
53	Kitchen Remodel - Feed for Mobil Kitchen	2015	3,378		20	169	169	437	53
54	Replace Relief Valve/Steam Header/Traps - Boiler	2015	27,342		20	1,367	1,367	3,987	54
55	Plumbing Boiler Room	2015	3,773		20	189	189	409	55
56	Hot Water Piping	2015	3,406		20	170	170	354	56
57	Water Meter	2016	7,798		20	390	390	585	57
58	Emergency Electrical System	2016	34,013		20	1,701	1,701	2,551	58
59	Hot Water Line Repairs	2016	4,992		20	250	250	375	59
60	Remodel Patient RMs 203&204, Walls, Flooring, Paint	2016	6,932		20	347	347	520	60
61	Electric Energy Storage Imporvements - Entire Facility	2017	56,566		20	1,886	1,886	1,886	61
62	Wing 1 20 Ton Air Conditioner	2017	12,260		20	409	409	409	62
63	Wing 3 Air Conditioner Compressor	2017	5,883		20	25	25	25	63
64	Facility Plumbing and Labor / Water Softner Install	2017	12,969		20	432	432	432	64
65									65
66									66
67									67
68									68
69	Book Depreciation			234,859			(234,859)		69
70	TOTAL (lines 4 thru 69)		$ 8,188,058	$ 234,859		$ 213,771	$ (21,088)	$ 4,628,301	70

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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	$ 1,885,206	$	$ 52,087	$ 52,087	5	$ 1,468,386	71
72	Current Year Purchases	40,478		4,048	4,048	5	4,048	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,925,684	$	$ 56,135	$ 56,135		$ 1,472,434	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 Truck	1995	$ 17,024	$	$	$		$	76
77		Van	2005	78,436						77
78		Truck Overhaul	2014	2,882		576	576	5	1,920	78
79		Dodge 2500 Promaster Van	2017	56,569		3,771	3,771	5	3,771	79
80	TOTALS			$ 154,911	$	$ 4,347	$ 4,347		$ 5,691	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)	$ 10,424,653	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 234,859	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 274,253	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 39,394	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,106,426	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: 12/1/2016 Ending: 11/30/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 9,444 Description: Postage Meter - $660; Oxygen Tanks - $1,574; Copy Machine - $6,210; Time Clock - $1,000
(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: 12/1/2016 Ending: 11/30/2017

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: 12/1/2016 Ending: 11/30/2017

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	39-3	hrs	$		$ 204,274	$		$ 204,274	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			72,133			72,133	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			203,481			203,481	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				100,452		100,452	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen/Supplies	39-2					12,468		12,468	12
13	Other (specify):									13
14	TOTAL			$		$ 479,888	$ 112,920		$ 592,808	14

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

Facility Name & ID Number Knox County Nursing Home **#** 0010561 **Report Period Beginning:** 12/1/2016 **Ending:** 11/30/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/2017 **(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	$ 500,377	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,270,000))	776,666		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	815,548		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,092,591	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	643,037		12
13	Land	156,600		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	9,167,141		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(6,630,613)		17
18	Deferred Charges	720,086		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): Transfer to Other Funds	60,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,116,251	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,208,842	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 196,750	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,317,321		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	27,230		36
37	Deferred Property Taxes	804,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,345,301	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,345,301	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,863,541	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,208,842	$	48

***(See instructions.)**

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,518,315	1
2	Restatements (describe):		2
3	**Audit Adjustments posted after PY cost report**	87,286	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,605,601	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,742,060)	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)**	$ (1,742,060)	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)**	$ 3,863,541	24 *

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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	$ 8,061,244	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,061,244	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	150,214	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 150,214	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	3,474	12
13	Barber and Beauty Care	4,138	13
14	Non-Patient Meals	11,187	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	28,469	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 47,268	23
	D. Non-Operating Revenue		
24	Contributions	20,000	24
25	Interest and Other Investment Income***	12,249	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 32,249	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	921,325	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 921,325	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,212,300	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,894,315	31
32	Health Care	4,100,224	32
33	General Administration	3,725,853	33
	B. Capital Expense		
34	Ownership	244,303	34
	C. Ancillary Expense		
35	Special Cost Centers	617,237	35
36	Provider Participation Fee	372,428	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,954,360	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,742,060)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,742,060)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,533,589	44
45	Private Pay - Net Inpatient Revenue	3,133,352	45
46	Medicare - Net Inpatient Revenue	868,359	46
47	Other-(specify) Insurance	279,285	47
48	Other-(specify) Hospice	246,659	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,061,244	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	130,702
	TRANS IN -REFERENDUM	633,223
	FARM INCOME	7,513
	TRANS TO OTHER FUNDS	(633,223)
	CURRENT PROPERTY TAX	781,182
	UNANTICIPATED REVENUE	1,928
	Total	**921,325**

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

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	2,096	2,236	$ 68,792	$ 30.77	1
2	Assistant Director of Nursing	2,080	2,120	59,369	28.00	2
3	Registered Nurses	23,130	28,659	617,652	21.55	3
4	Licensed Practical Nurses	39,982	46,435	757,551	16.31	4
5	CNAs & Orderlies	157,240	175,993	2,175,456	12.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,783	2,080	33,130	15.93	9
10	Activity Assistants	7,389	8,420	61,839	7.34	10
11	Social Service Workers	10,498	11,179	145,399	13.01	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,120	47,909	22.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	36,330	35,421	406,894	11.49	15
16	Dishwashers					16
17	Maintenance Workers	8,524	9,991	143,401	14.35	17
18	Housekeepers	21,283	23,855	245,247	10.28	18
19	Laundry	6,747	7,663	76,707	10.01	19
20	Administrator	2,096	2,236	74,026	33.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,831	13,142	178,981	13.62	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	1,494	1,592	22,299	14.01	33
34	TOTAL (lines 1 - 33)	334,543	373,142	$ 5,114,652 *	$ 13.71	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	239	$ 9,575	1-3	35
36	Medical Director	Monthly	9,750	9-3	36
37	Medical Records Consultant	Quarterly	3,106	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,196	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	Quarterly	594	10-3	47
48					48
49	TOTAL (lines 35 - 48)	239	$ 35,221		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	1,556	37,876	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,556	$ 37,876		53

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Secrist	Administrator	0%	$ 74,026
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,026

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
		$
Davis & Campbell	Legal	12,639
Wipfli	Accounting/Audit	4,725
FGMK, LLC	Healthcare Consulting	8,500
Knox County	Reimbursed IT	25,671
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 51,535

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 230,647
Unemployment Compensation Insurance	24,732
FICA Taxes	386,184
Employee Health Insurance	940,326
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	440,611
Trans In-SS	(112,556)
Trans from IMRF	(225,113)
IMRF NPO	594,181
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,279,012

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	659
Health Care Worker Background Check	1,085
(Indicate # of checks performed 67)	
Patient Background Checks 111	1,110
Pre Employment Testing	28,281
Dues & Subscriptions	1,960
Marketing Services	5,111
Less: Public Relations Expense	( )
Non-allowable advertising	(5,111)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,075

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,383
Seminar Expense	3,364
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,747

* Attach copy of IMRF notifications

**See instructions.

Knox County Nursing Home
0010561
Page 21- Supplemental -Seminar Expense
12/1/2016-11/30/2017

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE
	RAMIREZ	CONSULT W/ ACT & SS	KRISTEN/TAMMIE/KEVIN	Activity/ Social Services	IN HOUSE	225.00
	SPOON RIVER INSERVIES	ACTIVITY WORKSHOP	TAMMIE, KRISTEN	Activity	Macomb, IL	40.00
	DIETARY TRAINING	DIETARY	ALL DIETARY EMPLOYEES	Dietary	Galesburg, IL	175.00
	TRAINING MODULES	PROF MED	ALL EMPLOYEES	Various	IN HOUSE	895.95
	MED PASS	POLICY PROCDURE UPDATES	NURSING HOME		IN HOUSE	199.50
2/22/2017	PESI / RACHEL WILLIAIMS	LTC	Rachel	Admin	IN HOUSE	199.99
3/1/2017	AANAC	004-000-580560-55		TRAINING		119.00
10/31/2017	ILL NURSING HOME	ROPs	RACHEL KEVIN DONNA	TRAINING	SPRINGFIELD	375.00
10/27/2017	IHCA	Disaster Planning	JON	TRAINING	SPRINGFIELD	150.00
8/7/2017	AANAC	ROPs	RACHEL KEVIN DONNA	TRAINING	EAST PEORIA	95.00
6/7/2017	INHAA	004-000-580560-55	RACHEL TAMMY	TRAINING	EAST PEORIA	190.00
3/16/2017	AANAC	004-000-580560-55	ANGIE WHITMAN	MDS WORKSHOP	ONLINE	180
10/25/17	PATHWAY HEALTH	044-000-690000-55			IN HOUSE	520.00
						3,364.44

Knox County Nursing Home
0010561
Page 21- Supplemental -Legal Expense
12/1/2016-11/30/2017

Date	G/L Acct	Payee Vendor	Service	Amount
12/13/16	004-000-560260-55	DAVIS & CAMPBELL	Legal	290
1/16/17	004-000-560260-55	DAVIS & CAMPBELL	Legal	507.5
1/16/17	004-000-560260-55	DAVIS & CAMPBELL	Legal	72.5
2/14/17	004-000-560260-55	DAVIS & CAMPBELL	Legal	797.5
3/15/17	004-000-560260-55	DAVIS & CAMPBELL	Legal	72.5
4/11/17	004-000-560260-55	DAVIS & CAMPBELL	Legal	290
4/11/2017	004-000-560260-55	DAVIS & CAMPBELL	Legal	362.5
5/9/17	004-000-560260-55	DAVIS & CAMPBELL	Legal	1232.5
6/12/17	004-000-560260-55	DAVIS & CAMPBELL	Legal	1957.5
7/12/2017	004-000-560260-55	DAVIS & CAMPBELL	Legal	290
7/12/2017	004-000-560260-55	DAVIS & CAMPBELL	Legal	2465
8/16/2017	004-000-560260-55	DAVIS & CAMPBELL	Legal	1380.5
9/12/17	004-000-560260-55	DAVIS & CAMPBELL	Legal	362.5
10/10/2017	004-000-560260-55	DAVIS & CAMPBELL	Legal	2486
10/10/2017	004-000-560260-55	DAVIS & CAMPBELL	Legal	72.5
				12639

Knox County Nursing Home
0010561
Page 21- Supplemental -Travel Expense
12/1/2016-11/30/2017

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATIC	PURPOSE OF TRIP	Fuel	AIRFARE	HOTEL	TOTAL
5/15/2017	JON REYES	ENVIR SERVICES	Springfield	Training			237.3	237.3
10/27/20417	JON REYES	GAS EXPENSE	SPRINGFIELD	CONFERENCE	127.68			127.68
11/3/2017	ANGIE WHITMA	GAS EXPENSE	MOLINE IL	CONFERENCE	57.12			57.12
8/16/2017	MEG WICKS	GAS EXPENSE	PEORIA IL	CONFERENCE	106.40			106.4
9/6/2017	MEG WICKS	GAS EXPENSE	PEORIA IL	CONFERENCE	51.52			51.52
6/15/2017	RACHEL	GAS EXPENSE	EAST PEORIA	CONFERENCE	108.86			108.86
5/19/2017	JON REYES	GAS EXPENSE	SPRINGFIELD	NFPA	142.24		109	251.24
Various	Various	Gas Expense	Van		2808			2808
		Motor Oil			203			203
		Truck			432			432
								4383.12

Knox County Nursing Home
0052589
Other Administrative Staff Transportation Schedule
12/1/2016-11/30/2017

Date	Employee Name	Reference	Amount
Various	Nursing Home Committee Members	Per Diem/Mileage	1770
		Total	**1770**

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2016 Ending: 11/30/2017

XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **35,525** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **372,428**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **14,661**

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

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **yes**
Attach invoices and a summary of services for all architect and appraisal fees