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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0010561

Facility Name: Knox County Nursing Home

Address: 800 North Market Street (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 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 12/1/2017 to 11/30/2018 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: 12/1/2017 Ending: 11/30/2018

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			1,436	1,436	8
9	SNF/PED					9
10	ICF	22,635	20,378		43,013	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,635	20,378	1,436	44,449	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.06%

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 1,179

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: 12/1/2017 Ending: 11/30/2018

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	427,059	27,946	8,974	463,979		463,979		463,979			1
2	Food Purchase		293,038		293,038		293,038	(12,554)	280,484			2
3	Housekeeping	249,769	24,178		273,947		273,947		273,947			3
4	Laundry	77,883	17,608	81,444	176,935		176,935		176,935			4
5	Heat and Other Utilities			203,734	203,734		203,734		203,734			5
6	Maintenance	138,252	2,415	125,152	265,819		265,819	(68,050)	197,769			6
7	Other (specify):*											7
8	TOTAL General Services	892,963	365,185	419,304	1,677,452		1,677,452	(80,604)	1,596,848			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	3,538,294	164,119	341,107	4,043,520		4,043,520		4,043,520			10
10a	Therapy		224		224		224		224			10a
11	Activities	105,343	4,905		110,248		110,248		110,248			11
12	Social Services	152,164	731	590	153,485		153,485		153,485			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,795,801	169,979	350,697	4,316,477		4,316,477		4,316,477			16
	C. General Administration											
17	Administrative	68,437			68,437		68,437		68,437			17
18	Directors Fees											18
19	Professional Services			141,953	141,953		141,953		141,953			19
20	Dues, Fees, Subscriptions & Promotions			44,473	44,473		44,473	(5,627)	38,846			20
21	Clerical & General Office Expenses	167,500	11,479	220,437	399,416		399,416	(111,645)	287,771			21
22	Employee Benefits & Payroll Taxes			1,644,400	1,644,400		1,644,400	314,444	1,958,844			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,299	7,299		7,299		7,299			24
25	Other Admin. Staff Transportation			2,096	2,096		2,096		2,096			25
26	Insurance-Prop.Liab.Malpractice			82,907	82,907		82,907		82,907			26
27	Other (specify):*											27
28	TOTAL General Administration	235,937	11,479	2,143,565	2,390,981		2,390,981	197,172	2,588,153			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,924,701	546,643	2,913,566	8,384,910		8,384,910	116,568	8,501,478			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: 12/1/2017 Ending: 11/30/2018

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			229,473	229,473		229,473	65,663	295,136			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			7,549	7,549		7,549		7,549			35
36	Other (specify):*											36
37	**TOTAL Ownership**			237,022	237,022		237,022	65,663	302,685			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		87,779	433,525	521,304		521,304		521,304			39
40	Barber and Beauty Shops	23,155		870	24,025		24,025	(4,490)	19,535			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			401,558	401,558		401,558		401,558			42
43	Other (specify):* **Property Tax**			903	903		903	(903)				43
44	**TOTAL Special Cost Centers**	23,155	87,779	836,856	947,790		947,790	(5,393)	942,397			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,947,856	634,422	3,987,444	9,569,722		9,569,722	176,838	9,746,560			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: 12/1/2017 Ending: 11/30/2018

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	(12,554)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,840)	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	65,663	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	(111,645)	21		24
25	Fund Raising, Advertising and Promotional	(5,627)	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	(67,603)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (137,606)		$	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)	314,444		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 314,444		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 176,838		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: 12/1/2017

Ending: 11/30/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beauty Revenue Offset	$ (4,490)	40	1
2	Offset County Farm Tax	(903)	43	2
3	Capitalized R&M	(62,210)	6	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				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**	(67,603)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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	(12,554)	0	0	0	0	0	0	0	0	0	0	(12,554)	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	(68,050)	0	0	0	0	0	0	0	0	0	0	(68,050)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(80,604)	0	0	0	0	0	0	0	0	0	0	(80,604)	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	(5,627)	0	0	0	0	0	0	0	0	0	0	(5,627)	20
21	Clerical & General Office Expenses	(111,645)	0	0	0	0	0	0	0	0	0	0	(111,645)	21
22	Employee Benefits & Payroll Taxes	0	314,444	0	0	0	0	0	0	0	0	0	314,444	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**	(117,272)	314,444	0	0	0	0	0	0	0	0	0	197,172	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(197,876)	314,444	0	0	0	0	0	0	0	0	0	116,568	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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	65,663	0	0	0	0	0	0	0	0	0	0	65,663	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	65,663	0	0	0	0	0	0	0	0	0	0	65,663	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	(4,490)	0	0	0	0	0	0	0	0	0	0	(4,490)	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):*	(903)	0	0	0	0	0	0	0	0	0	0	(903)	43
44	TOTAL Special Cost Centers	(5,393)	0	0	0	0	0	0	0	0	0	0	(5,393)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(137,606)	314,444	0	0	0	0	0	0	0	0	0	176,838	45

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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	$ 26,854	Knox County		$ 26,854	$	1
2	V	22	IMRF County		Knox County		209,629	209,629	2
3	V	22	Payroll Taxes County		Knox County		104,815	104,815	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 26,854			$ 341,298	$ * 314,444	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: 12/1/2017 Ending: 11/30/2018

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	Patrick Harlan	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	Kyle A.C. Rohweder	BOD						9
10	Sara Varner	BOD						10
11	Jared Hawkinson	BOD						11
12	Todd Olinger	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: 12/1/2017 Ending: 11/30/2018

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	1,783	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	$ 1,783		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

Knox County Nursing Home
0052589
Other Administrative Staff Transportation Schedule
12/1/2017-11/30/2018

Date	Employee Name	Reference	Amount
Various	Nursing Home Committee Members	Per Diem/Mileage	1783
		Total	**1783**

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2017 Ending: 1/30/2018

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		$ 26,854	$	169	$ 26,854	1
2	22	IMRF- County	Direct Cost	169		209,629		169	209,629	2
3	22	Payroll Tax-County	Direct Cost	169		104,815		169	104,815	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					$ 341,298	$		$ 341,298	25

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

Facility is exempt from paying real estate taxes

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 12/1/2017 Ending: 11/30/2018

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: 12/1/2017 Ending: 11/30/2018

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	46,131	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	820	820	39,334	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	114,241	32
33	Various			2004	116,328		20	6,827	6,827	83,952	33
34	Various			2005	327,652		20	16,383	16,383	195,939	34
35	Various			2006	1,002,155		20	49,800	49,800	548,722	35
36	Various			2007	480,150		20	4,856	4,856	48,561	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: 12/1/2017 Ending: 11/30/2018

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	$ 74,735	37
38	Various	2009	386,135		20	12,487	12,487	112,409	38
39	Various	2010	34,807		20	1,758	1,758	15,114	39
40	Various	2011	1,483,738		20	74,187	74,187	321,792	40
41	Various	2012	184,474		20	9,224	9,224	52,558	41
42	Various	2013	40,116		20	2,006	2,006	10,773	42
43	Various	2014	207,582		20	10,379	10,379	45,013	43
44	Kitchen Remodel - Feed for Mobil Kitchen	2015	3,378		20	169	169	606	44
45	Replace Relief Valve/Steam Header/Traps - Boiler	2015	27,342		20	1,367	1,367	5,354	45
46	Plumbing Boiler Room	2015	3,773		20	189	189	598	46
47	Hot Water Piping	2015	3,406		20	170	170	524	47
48	Water Meter	2016	7,798		20	390	390	975	48
49	Emergency Electrical System	2016	34,013		20	1,701	1,701	4,252	49
50	Hot Water Line Repairs	2016	4,992		20	250	250	625	50
51	Remodel Patient RMs 203&204, Walls, Flooring, Paint	2016	6,932		20	347	347	867	51
52	Electric Energy Storage Imporvements - Entire Facility	2017	56,566		20	2,828	2,828	4,714	52
53	Wing 1 20 Ton Air Conditioner	2017	12,260		20	613	613	1,022	53
54	Wing 3 Air Conditioner Compressor	2017	5,883		20	294	294	319	54
55	Facility Plumbing and Labor / Water Softner Install	2017	12,969		20	648	648	1,080	55
56	American Standard 4 Ton Roof Top Cooling Unit/Electrical	2018	13,257		20	276	276	276	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			229,473			(229,473)		69
70	TOTAL (lines 4 thru 69)		$ 8,201,315	$ 229,473		$ 214,824	$ (14,649)	$ 4,831,886	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: 12/1/2017 Ending: 11/30/2018

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	$ 1,925,684	$	$ 60,183	$ 60,183	5	$ 1,532,617	71
72	Current Year Purchases	14,630		1,951	1,951		1,951	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,940,314	$	$ 62,134	$ 62,134		$ 1,534,568	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		Van	2005	$ 78,436	$	$	$	5	$	76
77		Dodge 2500 Promaster Van	2017	56,569		11,314	11,314	5	15,085	77
78		Ford F350	2018	34,322		6,864	6,864	5	6,864	78
79										79
80	TOTALS			$ 169,327	$	$ 18,178	$ 18,178		$ 21,949	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)	$ 10,466,956	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 229,473	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 295,136	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 65,663	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,388,403	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: 12/1/2017 Ending: 11/30/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 7,549 Description: Postage Meter - $660; Copy Machines/Timeclocks - $6889
(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: 12/1/2017 Ending: 11/30/2018

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: 12/1/2017 Ending: 11/30/2018

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	$		$ 188,927	$		$ 188,927	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			88,171			88,171	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			156,427			156,427	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				74,628		74,628	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen/Supplies	39-2					13,151		13,151	12
13	Other (specify):									13
14	TOTAL			$		$ 433,525	$ 87,779		$ 521,304	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: 12/1/2017 Ending: 11/30/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2018 (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	$ 632,895	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (518,000))	460,947		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	831,032		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,924,874	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,964		12
13	Land	156,600		13
14	Buildings, at Historical Cost	138,129		14
15	Leasehold Improvements, at Historical Cost	9,222,553		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(6,860,086)		17
18	Deferred Charges	(790,011)		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	11,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,884,149	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,809,023	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 177,509	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,034		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Others	23,623		36
37	Deferred Property Tax	819,500		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,163,666	$	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)**	$ 1,163,666	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,645,357	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,809,023	$	48

***(See instructions.)**

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/1/2017 Ending: 11/30/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,863,541	1
2	Restatements (describe):		2
3	**Audit Adjustments Posted after PY Cost Report**	(346,068)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,517,473	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(872,116)	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)**	$ (872,116)	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)**	$ 2,645,357	24 *

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

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,539,830	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,539,830	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	208,737	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 208,737	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	3,539	12
13	Barber and Beauty Care	4,490	13
14	Non-Patient Meals	9,015	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	17,857	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 34,901	23
	D. Non-Operating Revenue		
24	Contributions	48,677	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48,677	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	865,461	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 865,461	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,697,606	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,677,452	31
32	Health Care	4,316,477	32
33	General Administration	2,390,981	33
	B. Capital Expense		
34	Ownership	237,022	34
	C. Ancillary Expense		
35	Special Cost Centers	546,232	35
36	Provider Participation Fee	401,558	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,569,722	40
41	**Income before Income Taxes (line 30 minus line 40)****	(872,116)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (872,116)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,124,980	44
45	Private Pay - Net Inpatient Revenue	3,110,992	45
46	Medicare - Net Inpatient Revenue	651,854	46
47	Other-(specify) Insurance	258,951	47
48	Other-(specify) Hospice	393,053	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,539,830	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	60,484
	TRANS IN -REFERENDUM	706,379
	FARM INCOME	4,626
	TRANS TO OTHER FUNDS	(706,379)
	CURRENT PROPERTY TAX	798,834
	UNANTICIPATED REVENUE	1,517
	Total	**865,461**

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,747	3,019	$ 86,498	$ 28.65	1
2	Assistant Director of Nursing	2,809	3,087	71,469	23.15	2
3	Registered Nurses	32,454	35,670	829,828	23.26	3
4	Licensed Practical Nurses	23,224	25,525	466,911	18.29	4
5	CNAs & Orderlies	141,630	161,439	2,083,588	12.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,261	4,719	36,903	7.82	9
10	Activity Assistants	4,270	4,729	68,440	14.47	10
11	Social Service Workers	11,648	13,083	152,164	11.63	11
12	Dietician					12
13	Food Service Supervisor	3,167	3,452	84,470	24.47	13
14	Head Cook	34,943	38,087	342,589	8.99	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	8,753	9,685	138,252	14.27	17
18	Housekeepers	21,377	24,906	249,769	10.03	18
19	Laundry	6,824	7,950	77,883	9.80	19
20	Administrator	1,520	1,616	68,437	42.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,607	12,722	167,500	13.17	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	1,461	1,560	23,155	14.84	33
34	TOTAL (lines 1 - 33)	312,695	351,249	$ 4,947,856 *	$ 14.09	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	228	$ 8,974	1-3	35
36	Medical Director	Monthly	9,000	9-3	36
37	Medical Records Consultant	Quaterly	5,597	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,881	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	20	590	12-3	45
46	Other(specify)				46
47	Physician Consultant	1	147	10-3	47
48					48
49	TOTAL (lines 35 - 48)	249	$ 35,189		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,216	$ 42,561	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	11,277	281,921	10-3	52
53	TOTAL (lines 50 - 52)	12,493	$ 324,482		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Secrist	Administrator	0%	$ 68,437
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 68,437

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
Wipfli	Audit	$ 4,750
Davis & Campbell	Legal	16,380
FGMK, LLC	Healthcare Consulting	12,818
Knox County	Reimbursed IT	26,584
Wipfli	Claim Review	81,421
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 141,953

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 203,299
Unemployment Compensation Insurance	16,443
FICA Taxes	369,324
Employee Health Insurance	812,307
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	439,412
Trans In - SS	(104,815)
Trans From IMRF	(209,629)
IMRF NPO	118,059
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,644,400

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	121
Health Care Worker Background Check	
(Indicate # of checks performed 54)	1,354
Patient Background Checks 99	990
Pre Employment Testing	36,058
Dues and Subscriptions	323
Marketing Services	5,627
Less: Public Relations Expense	(5,627)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,846

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,814
Seminar Expense	2,485
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,299

* Attach copy of IMRF notifications

**See instructions.

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE
	CLASSIC ACCENTS	NAME TAGS	ALL STAFF	TRAINING	IN HOUSE	405.00
	AMSTERDAM	EMPLOYEE FOLDERS		TRAINING	IN HOUSE	220.00
	RAMIREZ	CONSULT W/ ACT & SS	KRISTEN/TAMMIE/KEVIN	TRAINING	IN HOUSE	190.00
	PATHWAY HEALTH SERVICE	CARE PLAN TRAINING	HELP WITH CARE PLANS	PUT IN PCC	INH	687.50
	DIETARY TRAINING	KOHL	ALL DIETARY EMPLOYEES	TRAINING	IN HOUSE	336.00
	FOOD CARDS	EFOOD CARD	DIETARY	TRAINING	ON LINE	15.98
12/26/2017	AANAC	004-000-580560-55	JORI	TRAINING	SPRINGFIELD	125.00
2/27/2018	AANAC	004-000-580560-55	RACHEL KEVIN DONNA	TRAINING	EAST PEORIA	124.00
3/28/2018	INHAA	004-000-580560-55	ANNIE	TRAINING	EAST PEORIA	200.00
6/27/2018	INHAA	004-000-580560-55	JORI RACHEL	TRAINING	EAST PEORIA	100.00
12/26/2017	AANAC	004-000-580560-55	ANGIE WHITMAN	MDS WORKSHOP	ONLINE	81.9
						2,485.38

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Page 21- Supplemental -Legal Expense
12/1/2017-11/30/2018

Date	G/L Acct	Payee Vendor	Service	Amount
1/24/18	004-000-560260-55	DAVIS & CAMPBELL	Legal	145
1/24/18	004-000-560260-55	DAVIS & CAMPBELL	Legal	3842
1/24/18	004-000-560260-55	DAVIS & CAMPBELL	Legal	2320
1/24/18	004-000-560260-55	DAVIS & CAMPBELL	Legal	435
4/25/18	004-000-560260-55	DAVIS & CAMPBELL	Legal	580
4/25/18	004-000-560260-55	DAVIS & CAMPBELL	Legal	72.5
4/25/2018	004-000-560260-55	DAVIS & CAMPBELL	Legal	217.5
4/25/18	004-000-560260-55	DAVIS & CAMPBELL	Legal	72.5
4/25/18	004-000-560260-55	DAVIS & CAMPBELL	Legal	145
4/25/2018	004-000-560260-55	DAVIS & CAMPBELL	Legal	2682.5
6/27/2018	004-000-560260-55	DAVIS & CAMPBELL	Legal	145
6/27/2018	004-000-560260-55	DAVIS & CAMPBELL	Legal	1087.5
6/27/18	004-000-560260-55	DAVIS & CAMPBELL	Legal	435
11/28/2018	004-000-560260-55	DAVIS & CAMPBELL	Legal	435
11/28/2018	004-000-560260-55	DAVIS & CAMPBELL	Legal	1087.5
11/28/2018	004-000-560260-55	DAVIS & CAMPBELL	Legal	217.5
				2460
				16379.5

Knox County Nursing Home
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Page 21- Supplemental -Travel Expense
12/1/2017-11/30/2018

DATE	EMPLOYEE NAME	JOB DESCRIPTIO	DESTINATIC	PURPOSE OF TRIP	Fuel	AIRFARE	HOTEL	TOTAL
Various	Various	Gas Expense	Van		3476			3476
		Motor Oil			366			366
		Truck			972			972
								4814

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XX. GENERAL INFORMATION:

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

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

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **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. $ **30,526** 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. $ **401,558**
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. $ **12,554**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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