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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT) FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0021832

Facility Name: A MERKLE C KNIPPRATH N H

Address: 1190 E 2900 NORTH RD (Number) CLIFTON (City) 60927 (Zip Code)

County: IROQUOIS

Telephone Number: 815-694-2306 **Fax #** 815-694-2818

HFS ID Number:

Date of Initial License for Current Owners: 01-01-1975

Type of Ownership:

[X] VOLUNTARY,NON-PROFIT	[ ] PROPRIETARY	[ ] GOVERNMENTAL
[X] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code 501C3	[ ] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other	

In the event there are further questions about this report, please contact:
Name: PAULA MILLER Telephone Number: 816-596-5608
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 7/1/19 to 6/30/20 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)	MICHAEL GORDON
	(Title)	CFO
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Eric J. Neidig Senior Manager
	(Firm Name & Address)	Bradley Associates 201 S Capitol Ave, Suite 700, Indianapolis, IN 46225
	(Telephone)	(317) 237-5500 Fax # (317) 237-5503

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 A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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 NONE

	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	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	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	15,830	5,360	1,680	22,870	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,830	5,360	1,680	22,870	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.12%

D. How many bed reserve days during this year were paid by the Department? 0 (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)
N/A - 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 10-06-75

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10-01-13 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 1,676

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 6-30-20 Fiscal Year: 6-30-20

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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		16,713	445,899	462,612		462,612		462,612			1
2	Food Purchase		169,742		169,742		169,742	(5,918)	163,824			2
3	Housekeeping	118,302	34,047	2,299	154,648		154,648	2,468	157,116			3
4	Laundry		10,416	13,609	24,025		24,025	(6,237)	17,788			4
5	Heat and Other Utilities			149,803	149,803		149,803	2,244	152,047			5
6	Maintenance	101,674	39,031	112,878	253,583		253,583	1,863	255,446			6
7	Other (specify):* Pastoral	44,081	1,390	1,830	47,301		47,301		47,301			7
8	**TOTAL General Services**	264,057	271,339	726,318	1,261,714		1,261,714	(5,580)	1,256,134			8
	B. Health Care and Programs											
9	Medical Director	1,600		1,600	3,200		3,200		3,200			9
10	Nursing and Medical Records	1,722,274	191,216	331,017	2,244,507		2,244,507		2,244,507			10
10a	Therapy			229,171	229,171		229,171		229,171			10a
11	Activities	89,441	3,697	3,760	96,898		96,898		96,898			11
12	Social Services	33,929		972	34,901		34,901		34,901			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,847,244	194,913	566,520	2,608,677		2,608,677		2,608,677			16
	C. General Administration											
17	Administrative	127,888		662,413	790,301		790,301	(662,413)	127,888			17
18	Directors Fees											18
19	Professional Services			4,971	4,971		4,971	(2,210)	2,761			19
20	Dues, Fees, Subscriptions & Promotions			17,940	17,940		17,940	(231)	17,709			20
21	Clerical & General Office Expenses	132,848	11,521	15,155	159,524		159,524	677,185	836,709			21
22	Employee Benefits & Payroll Taxes			518,676	518,676		518,676	(2,786)	515,890			22
23	Inservice Training & Education			707	707		707		707			23
24	Travel and Seminar			1,190	1,190		1,190		1,190			24
25	Other Admin. Staff Transportation			784	784		784		784			25
26	Insurance-Prop.Liab.Malpractice							235,427	235,427			26
27	Other (specify):*											27
28	**TOTAL General Administration**	260,736	11,521	1,221,836	1,494,093		1,494,093	244,972	1,739,065			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,372,037	477,773	2,514,674	5,364,484		5,364,484	239,392	5,603,876			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 A MERKLE C KNIPPRATH N H #0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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			114,017	114,017		114,017	157,757	271,774			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,842	32,842		32,842	(1,679)	31,163			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,354	21,354		21,354		21,354			35
36	Other (specify):*											36
37	**TOTAL Ownership**			168,213	168,213		168,213	156,078	324,291			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			466,364	466,364		466,364		466,364			39
40	Barber and Beauty Shops			1,435	1,435		1,435		1,435			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			185,215	185,215		185,215		185,215			42
43	Other (specify):* **Lab/Radiology**			8,419	8,419		8,419		8,419			43
44	**TOTAL Special Cost Centers**			661,433	661,433		661,433		661,433			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,372,037	477,773	3,344,320	6,194,130		6,194,130	395,470	6,589,600			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 A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,918)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	141,176	30		9
10	Interest and Other Investment Income	(1,679)	32		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				24
25	Fund Raising, Advertising and Promotional	(688)	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 PG5A	(8,702)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 124,189		$	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)	271,281	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 271,281		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 395,470		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.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44			X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

A MERKLE C KNIPPRATH N H

ID# 0021832

Report Period Beginning: 7/1/19

Ending: 6/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Laundry Revenue	$ (6,237)	4	1
2	Non-Allowable Legal Fees	(2,210)	19	2
3	Lobbying	(255)	21	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
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31				31
32				32
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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**	(8,702)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	(5,918)	0	0	0	0	0	0	0	0	0	0	(5,918)	2
3	Housekeeping	0	2,468	0	0	0	0	0	0	0	0	0	2,468	3
4	Laundry	(6,237)	0	0	0	0	0	0	0	0	0	0	(6,237)	4
5	Heat and Other Utilities	0	2,244	0	0	0	0	0	0	0	0	0	2,244	5
6	Maintenance	0	1,863	0	0	0	0	0	0	0	0	0	1,863	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,155)	6,575	0	0	0	0	0	0	0	0	0	(5,580)	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	(662,413)	0	0	0	0	0	0	0	0	0	(662,413)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,210)	0	0	0	0	0	0	0	0	0	0	(2,210)	19
20	Fees, Subscriptions & Promotions	(688)	457	0	0	0	0	0	0	0	0	0	(231)	20
21	Clerical & General Office Expenses	(255)	677,440	0	0	0	0	0	0	0	0	0	677,185	21
22	Employee Benefits & Payroll Taxes	0	(2,786)	0	0	0	0	0	0	0	0	0	(2,786)	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	235,427	0	0	0	0	0	0	0	0	0	235,427	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,153)	248,125	0	0	0	0	0	0	0	0	0	244,972	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,308)	254,700	0	0	0	0	0	0	0	0	0	239,392	29

STATE OF ILLINOIS — Summary B

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	141,176	16,581	0	0	0	0	0	0	0	0	0	157,757	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,679)	0	0	0	0	0	0	0	0	0	0	(1,679)	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	139,497	16,581	0	0	0	0	0	0	0	0	0	156,078	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	124,189	271,281	0	0	0	0	0	0	0	0	0	395,470	45

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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
Rhonda Anderson	BOD	Ascension Health Senior Care	Various	Ascension Health	Various	Healthcare System
Brad Partridge	BOD	Presence Our Lady of Victory	Bourbonnais	Suburban Pharmacy	Various	Pharmacy
Stuart Marcus	BOD	Presence Cor Mariae Center	Rockford			
Danny Stricker	BOD	Presence St. Joseph Center	Freeport			
Michelle Hereford	BOD	Presence St. Anne Center	Rockford			
		Presence Villa Franciscan	Joliet			
		Presence Heritage Village	Kankakee			

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	3	Housekeeping	$	Ascension Health		$ 2,468	$ 2,468	1
2	V	5	Utilities		Ascension Health		2,244	2,244	2
3	V	6	Maintenance		Ascension Health		1,863	1,863	3
4	V	17	Administration	662,413	Ascension Health			(662,413)	4
5	V	20	Dues and Fees		Ascension Health		457	457	5
6	V	21	Clerical and General Office		Ascension Health		677,440	677,440	6
7	V	22	Benefits	348,453	Ascension Health		345,667	(2,786)	7
8	V	26	Insurance		Ascension Health		235,427	235,427	8
9	V	30	Depreciation		Ascension Health		16,581	16,581	9
10	V	32	Interest		Ascension Health				10
11	V	39	Pharmacy	466,222	Suburban Pharmacy		466,222		11
12	V								12
13	V								13
14	Total			$ 1,477,088			$ 1,748,369	$ * 271,281	14

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

STATE OF ILLINOIS

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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			Presence Maryhaven Nursing & Rehab Center	Glenview				1
2			Presence Nazarethville	Des Plaines				2
3			Presence Resurrection Life Center	Chicago				3
4			Presence Resurrection Nursing & Rehab Center	Park Ridge				4
5			Presence Villa Scalabrini Nursing & Rehab Cen	Northlake				5
6			Presence McAuley Manor	Aurora				6
7			Presence St. Benedict	Niles				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

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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: Ascension Health
Street Address: 12250 Weber Hill Road
City / State / Zip Code: St Louis, Missouri 63127
Phone Number: (816-596-5608
Fax Number: ( )

	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	3	Housekeeping	Direct Cost	Various	15	$ 64,428	$	Various	$ 2,468	1
2	5	Utilities	Direct Cost	Various	15	58,570		Various	2,244	2
3	6	Maintenance	Direct Cost	Various	15	48,629		Various	1,863	3
4	20	Dues and Fees	Direct Cost	Various	15	11,937		Various	457	4
5	21	Clerical and General Office	Direct Cost	Various	15	17,746,043	2,702,670	Various	677,440	5
6	22	Benefits	Direct Cost	Various	15	9,071,146		Various	345,667	6
7	26	Insurance	Direct Cost	Various	15	5,495,348		Various	235,427	7
8	30	Depreciation	Direct Cost	Various	15	432,797		Various	16,581	8
9	32	Interest	Direct Cost	Various	15	275,620		Various	0	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					$ 33,204,518	$ 2,702,670		$ 1,282,147	25

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ ____________ **Line #** __________

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

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME A MERKLE C KNIPPRATH N H COUNTY IROQUOIS

FACILITY IDPH LICENSE NUMBER 0021832

CONTACT PERSON REGARDING THIS REPORT Paula Miller

TELEPHONE 816-596-5608 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,919 B. General Construction Type: Exterior Brick Frame Masonary 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).

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	NURSING HOME	1,730,560	1975	$ 24,225	1
2	FARM/ILU	995,072	1975	32,775	2
3	TOTALS	2,725,632		$ 57,000	3

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	99		2013	1975	$ 773,036	$	40	$	$	$ 773,036	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1986	324,830	3,628	40	8,121	4,493	281,000	9
10	VARIOUS			1995	177,260	3,300	24	7,386	4,086	162,031	10
11	VARIOUS			1998	7,339		20			7,339	11
12	VARIOUS			2000	53,780	1,201	20	2,689	1,488	44,858	12
13	VARIOUS			2001	12,094		15			12,094	13
14	VARIOUS			2002	69,025	1,469	21	3,287	1,818	55,952	14
15	VARIOUS			2003	52,773	1,179	20	2,639	1,460	44,814	15
16	VARIOUS			2004	54,894		13			54,894	16
17	VARIOUS			2005	3,058	30	13	67	37	3,058	17
18	VARIOUS			2006	12,830	382	15	855	473	11,956	18
19	VARIOUS			2007	18,065	475	17	1,063	588	15,429	19
20	VARIOUS			2008	141,675	4,522	14	10,120	5,598	119,679	20
21	VARIOUS			2009	87,276	2,437	16	5,455	3,018	56,065	21
22	VARIOUS			2012	3,155	141	10	316	175	2,525	22
23											23
24	8 PTAC AC UNITS INSULATED WALL			2014	7,124	318	10	712	394	4,290	24
25	ELECTRICAL PROBLEMS WITH AC UN			2014	3,826	171	10	383	212	2,280	25
26	FURNACE FOR EAST HALLWAY			2014	2,613	78	15	174	96	1,052	26
27	MATERIAL LABOR ENTRY HALL DINI			2014	262,443	7,817	15	17,496	9,679	105,985	27
28	PAINTING TO 6 UNITS AND COMMON			2014	4,000	18	5	40	22	4,000	28
29	THERAPY ACTIVITY ROOM FLOORING			2014	14,636	436	15	976	540	5,841	29
30	THERAPY ROOM PTAC UNITS			2014	3,495	156	10	349	193	2,081	30
31	WIRELESS INTERNET			2014	73,173	3,269	10	7,317	4,048	49,610	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	D.W. PAYNE 2 TON 13 SEER AC UN	2015	$ 3,100	$ 69	20	$ 155	$ 86	$ 723	37
38	ELECTRICAL RE WIRING IN PRIVATE THERAPY SUITE	2015	33,271	743	20	1,664	921	9,012	38
39	GAS FURNACE	2015	3,400	101	15	227	126	1,342	39
40	HVAC UPGRADES	2015	24,890	741	15	1,659	918	8,711	40
41	LABOR FOR INSTALLATION OF LIGH	2015	12,788	381	15	853	472	5,047	41
42	LIGHTING AND FIXTURES	2015	11,268	336	15	751	415	4,434	42
43	NURSE STATION REMODEL	2015	27,146	606	20	1,357	751	6,447	43
44	PATIENT TRANSPORTATION SLINGS	2015	16,628	371	20	831	460	4,937	44
45	INSTALL NEW WINDOWS/CARPET IN PVT THERAPY SUIT	2015	40,389	902	20	2,019	1,117	10,938	45
46	PTAC A C UNIT	2015	73,265	3,274	10	7,327	4,053	41,843	46
47	CONSTRUCTION OF 14 PVT THRPY RMS IN ARTHUR HALI	2015	143,565	3,207	20	7,178	3,971	38,882	47
48	NEW PAINT/FLOORING/SINKS IN RESIDENT ROOMS	2015	99,094	2,214	20	4,955	2,741	22,710	48
49	RESIDENT ROOM RENOVATIONS CEIL	2015	96,479	1,078	40	2,412	1,334	12,261	49
50	ROOFING AND RELATED WORK	2015	415,700	9,286	20	20,785	11,499	118,200	50
51	TELEVISIONS AND MOUNTING BRACK	2015	15,584	1,393	5	3,117	1,724	15,065	51
52	TUCKPOINTING MASONRY	2015	26,235	469	25	1,049	580	5,421	52
53	WINDOW TREATMENTS	2015	4,655	416	5	931	515	4,577	53
54	NEW TUCKPOINTING	2015	61,915	1,383	20	3,096	1,713	14,189	54
55									55
56	New Villa Patio	2016	46,432	519	40	1,161	642	7,681	56
57	RESIDENT ROOM RENOVATIONS - Flooring, Walls, Paint	2015	42,902	958	20	2,145	1,187	9,653	57
58	NEW WELL PUMP	2016	8,706	259	15	580	321	2,611	58
59									59
60	NEW CONCRETE PATIO & WALKWAY	2017	13,848	309	20	692	383	1,961	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,383,659	$ 60,042		$ 134,389	$ 74,347	$ 2,166,514	70

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,383,659	$ 60,042		$ 134,389	$ 74,347	$ 2,166,514	1
2	Aerated Fac Lagoon	2018	97,500	2,178	20	4,875	2,697	4,875	2
3	Emergency Panel Upgrade	2018	2,692	60	20	135	75	135	3
4	Carrier Furnace	2018	7,200	322	10	720	398	720	4
5	Heat Pump, Labor, Equipment, Ma	2018	6,485	290	10	649	359	649	5
6	Replace Furnace in Apt 8	2019	3,900	174	10	390	216	390	6
7									7
8	CARRIER FURNACE	2019	7,200	214	15	480	266	960	8
9	Heat Pump Labor, Equipment, Maintenance	2019	6,485	290	10	649	359	1,298	9
10	Water Furnace Heat Pump Replacement	2019	2,975	133	10	298	165	596	10
11	Provide/Install Swaby Pump	2019	15,970	714	10	1,597	883	3,194	11
12	Install a New Roof of Brothe	2019	9,104	407	10	910	503	1,820	12
13									13
14	Automatic Sliding Door Replacement	2020	14,363	428	15	958	530	958	14
15	7/1/19 Capital Rate Adjustments	2020	(765,083)						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	TOTAL (lines 1 thru 33)		$ 2,792,450	$ 65,252		$ 146,050	$ 80,798	$ 2,182,109	34

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	$ 1,236,348	$ 42,713	$ 95,601	$ 52,888	Various	$ 792,154	71
72	Current Year Purchases	121,829	6,052	13,542	7,490	Various	13,542	72
73	Fully Depreciated Assets	820,999					820,999	73
74	Home Office Allocation		16,581	16,581				74
75	TOTALS	$ 2,179,176	$ 65,346	$ 125,724	$ 60,378		$ 1,626,695	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 5,028,626	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 130,598	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 271,774	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 141,176	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,808,804	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 A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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.	/2021	$
13.	/2022	$
14.	/2023	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 21,354 Description: Nursing 19,799; Therapy 28; Admin 1,527.
   (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 A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$		$ 92,073	$		$ 92,073	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs			8,965			8,965	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs			121,311	6,822		128,133	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				474,782		474,782	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 222,349	$ 481,604		$ 703,953	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 A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/20 (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	$ 416,959	$ 8,136,691	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	535,536	42,004,394	3
4	Supply Inventory (priced at)		2,180,651	4
5	Short-Term Investments			5
6	Prepaid Insurance	2,635	1,976,079	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,507	93,121,433	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 958,637	$ 147,419,248	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		745,000	11
12	Long-Term Investments		170,652,019	12
13	Land	843,500	84,567,210	13
14	Buildings, at Historical Cost	1,627,517	480,997,625	14
15	Leasehold Improvements, at Historical Cost		5,209,074	15
16	Equipment, at Historical Cost	249,517	111,043,559	16
17	Accumulated Depreciation (book methods)	(262,075)	(228,817,338)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Misc Assets		11,647,941	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,458,459	$ 636,045,090	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,417,096	$ 783,464,338	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 647,729	$ 146,642,638	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	193,787	16,637,971	28
29	Short-Term Notes Payable		7,547,284	29
30	Accrued Salaries Payable	84,288	13,470,734	30
31	Accrued Taxes Payable (excluding real estate taxes)		122,805	31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,115,678	32
33	Accrued Interest Payable			33
34	Deferred Compensation		46,484,006	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Third Parties		4,954,006	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 925,804	$ 236,975,122	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		180,846,178	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)**	$	$ 180,846,178	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 925,804	$ 417,821,300	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,491,292	$ 365,643,038	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,417,096	$ 783,464,338	48

*(See instructions.)

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,279,071	1
2	Restatements (describe):		2
3	Adj to Reconcile	342,344	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,621,415	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,130,123)	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)**	$ (1,130,123)	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)**	$ 2,491,292	24 *

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

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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	$ 5,334,008	1
2	Discounts and Allowances for all Levels	(1,284,264)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,049,744	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	437,208	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 437,208	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	99,700	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	5,833	13
14	Non-Patient Meals	5,918	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	385,153	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 496,604	23
	D. Non-Operating Revenue		
24	Contributions	13,474	24
25	Interest and Other Investment Income***	1,679	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,153	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Income	65,298	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 65,298	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,064,007	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,261,714	31
32	Health Care	2,608,677	32
33	General Administration	1,494,093	33
	B. Capital Expense		
34	Ownership	168,213	34
	C. Ancillary Expense		
35	Special Cost Centers	476,218	35
36	Provider Participation Fee	185,215	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,194,130	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,130,123)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,130,123)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,168,895	44
45	Private Pay - Net Inpatient Revenue	1,483,520	45
46	Medicare - Net Inpatient Revenue	397,329	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,049,744	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	519	559	$ 36,284	$ 64.91	1
2	Assistant Director of Nursing	311	463	17,301	37.37	2
3	Registered Nurses	14,793	16,463	584,321	35.49	3
4	Licensed Practical Nurses	14,626	16,138	463,965	28.75	4
5	CNAs & Orderlies	33,582	37,257	620,403	16.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,872	2,104	35,309	16.78	9
10	Activity Assistants	4,091	4,479	54,132	12.09	10
11	Social Service Workers	1,584	1,998	33,929	16.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,539	6,065	101,674	16.76	17
18	Housekeepers	8,519	9,374	118,302	12.62	18
19	Laundry					19
20	Administrator	1,992	2,160	127,888	59.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,964	2,097	39,420	18.80	23
24	Clerical	3,704	3,991	49,774	12.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director			1,600		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 C: Admissions	1,192	1,443	43,654	30.25	32
33	Other(specify) Pastoral	987	1,109	44,081	39.75	33
34	TOTAL (lines 1 - 33)	95,275	105,700	$ 2,372,037 *	$ 22.44	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant	Monthly	1,600	9, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	1,159	11, 3	44
45	Social Service Consultant	11	972	12, 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	24	$ 3,731		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	385	$ 24,717	10	50
51	Licensed Practical Nurses	1,149	61,447	10	51
52	Certified Nurse Assistants/Aides	7,599	191,568	10	52
53	TOTAL (lines 50 - 52)	9,133	$ 277,732		53

Facility Name & ID Number A MERKLE C KNIPPRATH N H # 0021832 Report Period Beginning: 7/1/19 Ending: 6/30/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Grillion	Administrator		$ 127,888
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 127,888

B. Administrative - Other

Description	Amount
Corp Office Management Fee	$ 662,413
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 662,413

C. Professional Services

Vendor/Payee	Type	Amount
Universal Background Screening, Inc	HR Services	$ 2,761
Non-Allowable Legal Fees	Non-Allowable Legal Fees	2,210
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 4,971

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	174,197
Employee Health Insurance	256,568
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental	6,046
Life Insurance	2,114
Disability	15,809
Pension	44,278
Tuition Reimbursement	
Other Benefits	19,664
Home Office Allocation	(2,786)
TOTAL (agree to Schedule V, line 22, col.8)	$ 515,890

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 34)	
Patient Background Checks 28	
Dues & Subscriptions	17,252
Home Office Allocation	457
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,709

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,190
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,190

**See instructions.

Facility Name & ID Number **A MERKLE C KNIPPRATH N H** **#** **0021832** **Report Period Beginning:** **7/1/19** **Ending:** **6/30/20**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LEADING AGE - $4,242**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,790** 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. $ **185,215**
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. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **5,918**

(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? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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: **EY - PERFORMS CONSOLIDATED AUDIT OF ASCENSION HEALTH**

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

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