

		FOR OHF USE				

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**2003  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2003)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0010561</u></p> <p><b>Facility Name:</b> <u>Knox County Nursing Home</u></p> <p><b>Address:</b> <u>P. O. Box 219 - 800 N. Market Street</u> <u>Knoxville</u> <u>61448</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Knox</u></p> <p><b>Telephone Number:</b> <u>(309) 289-2338</u> <b>Fax #</b> <u>(309) 289-8384</u></p> <p><b>IDPA ID Number:</b> <u>376001167801</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>10/23/1946</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Charles J. Fischer</u> <b>Telephone Number:</b> <u>(312) 634-3400</u>  Please send copies of desk review and audit adjustments to address on this page</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/2002</u> to <u>11/30/2003</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1155 738 1291 820"></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1155 803 1291 820"></td> <td data-bbox="1291 803 1950 868">(Title) _____</td> </tr> <tr> <td data-bbox="1155 820 1291 1031">Paid Preparer</td> <td data-bbox="1291 820 1950 885">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td data-bbox="1155 885 1291 1031"></td> <td data-bbox="1291 885 1950 950">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1155 950 1291 1031"></td> <td data-bbox="1291 950 1950 1015">(Firm Name &amp; Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td data-bbox="1155 1015 1291 1031"></td> <td data-bbox="1291 1015 1950 1031">(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL																																					
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

# 0010561 Report Period Beginning: 12/01/2002 Ending: 11/30/2003

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	204	Skilled (SNF)	204	74,460	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	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Public Aid Recipient	3 Private Pay	4 Other	5 Total	
		8	SNF	11,800	4,523	
9	SNF/PED					9
10	ICF	30,092	13,254	36	43,382	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,892	17,777	4,150	63,819	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.71%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 08/28/1966

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date N/A NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 26 and days of care provided 3,969

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 11/30/2003 Fiscal Year: 11/30/2003

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/2002 Ending: 11/30/2003

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	381,972	29,724	8,693	420,389		420,389	420,389			1
2	Food Purchase		334,547		334,547		334,547	334,547			2
3	Housekeeping	239,742	45,941		285,683		285,683	285,683			3
4	Laundry	139,234	33,767	72,469	245,470		245,470	245,470			4
5	Heat and Other Utilities			232,826	232,826		232,826	232,826			5
6	Maintenance	122,455	4,220	299,715	426,390		426,390	(193,731)	232,659		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	883,403	448,199	613,703	1,945,305		1,945,305	(193,731)	1,751,574		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,195	7,195		7,195	7,195			9
10	Nursing and Medical Records	3,113,030	226,787	23,559	3,363,376		3,363,376	3,363,376			10
10a	Therapy			161,325	161,325		161,325	161,325			10a
11	Activities	97,836	8,316	2,296	108,448		108,448	108,448			11
12	Social Services	143,923	592	2,296	146,811		146,811	146,811			12
13	Nurse Aide Training										13
14	Program Transportation	17,483			17,483		17,483	17,483			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,372,272	235,695	196,671	3,804,638		3,804,638		3,804,638		16
	<b>C. General Administration</b>										
17	Administrative	97,277			97,277		97,277	97,277			17
18	Directors Fees			2,371	2,371		2,371	2,371			18
19	Professional Services			30,606	30,606		30,606	(2,764)	27,842		19
20	Dues, Fees, Subscriptions & Promotions			22,048	22,048		22,048	22,048			20
21	Clerical & General Office Expenses	158,442	11,254	30,116	199,812		199,812	20,904	220,716		21
22	Employee Benefits & Payroll Taxes			640,350	640,350		640,350	522,282	1,162,632		22
23	Inservice Training & Education			31,372	31,372		31,372	31,372			23
24	Travel and Seminar			1,770	1,770		1,770	1,770			24
25	Other Admin. Staff Transportation			5,078	5,078		5,078	5,078			25
26	Insurance-Prop.Liab.Malpractice			10,272	10,272		10,272	10,272			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	255,719	11,254	773,983	1,040,956		1,040,956	540,422	1,581,378		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,511,394	695,148	1,584,357	6,790,899		6,790,899	346,691	7,137,590		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

\*\* See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			145,200	145,200		145,200	15,482	160,682		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			2,519	2,519		2,519		2,519		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			147,719	147,719		147,719	15,482	163,201		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers	22,350	294,207	14,245	330,802		330,802		330,802		39
40	Barber and Beauty Shops	18,301	1,558		19,859		19,859		19,859		40
41	Coffee and Gift Shops			8,518	8,518		8,518		8,518		41
42	Provider Participation Fee			111,792	111,792		111,792		111,792		42
43	Other (specify):* <b>Nonallowable Costs</b>			21,257	21,257		21,257	(21,257)			43
44	<b>TOTAL Special Cost Centers</b>	40,651	295,765	155,812	492,228		492,228	(21,257)	470,971		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,552,045	990,913	1,887,888	7,430,846		7,430,846	340,916	7,771,762		45

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

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,957)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,482	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				24
25	Fund Raising, Advertising and Promotional	(26,072)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,694)	21		28
29	Other-Attach Schedule	(185,723)	var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (204,964)		\$	30

OHF 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	2	
		Amount	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)	545,880		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 545,880		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 340,916		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						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	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

**Knox County Nursing Home**

ID# 0010561

Report Period Beginning: 12/01/2002

Ending: 11/30/2003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Non-allowable cash-to-accrual basis adjustment	\$ 22,260	43	1
2	Out-of-period legal costs	(2,764)	19	2
3	Non-allowable Farm Account expenses	(11,488)	43	3
4	Capitalize repairs & maintenance expense	(193,731)	6	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(185,723)		49

See Accountants' Compilation Report

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nursing Home# 0010561

Report Period Beginning:

12/01/2002

Ending:

11/30/2003

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	(193,731)	0	0	0	0	0	0	0	0	0	0	(193,731)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(193,731)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(193,731)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(2,764)	0	0	0	0	0	0	0	0	0	0	(2,764)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(2,694)	23,598	0	0	0	0	0	0	0	0	0	20,904	21
22	Employee Benefits & Payroll Taxes	0	522,282	0	0	0	0	0	0	0	0	0	522,282	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	<b>TOTAL General Administration</b>	<b>(5,458)</b>	<b>545,880</b>	<b>0</b>	<b>540,422</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(199,189)</b>	<b>545,880</b>	<b>0</b>	<b>346,691</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/2002 Ending:

11/30/2003

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
30	Depreciation	15,482	0	0	0	0	0	0	0	0	0	0	15,482	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	<b>TOTAL Ownership</b>	<b>15,482</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>15,482</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(21,257)	0	0	0	0	0	0	0	0	0	0	(21,257)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(21,257)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(21,257)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(204,964)</b>	<b>545,880</b>	<b>0</b>	<b>340,916</b>	<b>45</b>								

Facility Name & ID Number Knox County Nursing Home

# 0010561

Report Period Beginning: 12/01/2002 Ending: 11/30/2003

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Knox County		N/A		N/A		

**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.**  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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 Bookkeeping & accounting	\$	Knox County	100.00%	\$ 23,598	\$ 23,598	1
2	V	22 Employee benefits - IMRF		Knox County	100.00%	146,743	146,743	2
3	V	22 Employee benefits - FICA		Knox County	100.00%	375,539	375,539	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		\$			\$ 545,880	\$ * 545,880	14

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

Facility Name & ID Number      Knox County Nursing Home      #      0010561      Report Period Beginning:      12/01/2002      Ending:      11/30/2003

## 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	W. Able	Board member	Administrative	0.00	0			Per diem	\$ 657	18(3)	1
2	L. Mannhardt	Board member	Administrative	0.00	0			& mileage	450	18(3)	2
3	G. Keiser	Board member	Administrative	0.00	0				372	18(3)	3
4	Parsons	Board member	Administrative	0.00	0				430	18(3)	4
5	S. Keener	Board member	Administrative	0.00	0				462	18(3)	5
6											6
7											7
8	NOTE: No member of the County Board provided direct services to the nursing home. In addition, no Board member has ownership in an entity that conducted										8
9	business transactions with the nursing home during the reporting period.										9
10											10
11											11
12											12
13								TOTAL	\$ 2,371		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/2002 Ending: 1/30/2003

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  NO

Name of Related Organization Knox County  
 Street Address 200 S. Cherry Street  
 City / State / Zip Code Galesburg, IL 61401  
 Phone Number ( 309) 345-3837  
 Fax Number ( 309) 343-7002

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Bookkeeping & accounting	Hours worked	2,166	2166	\$ 23,598	2,166	\$ 23,598	1
2	22	Employee benefits - IMRF	Direct cost	1	1			146,743	2
3	22	Employee benefits - FICA	Direct cost	1	1			375,539	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					\$ 23,598	\$	\$ 545,880	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/2002 Ending: 11/30/2003

**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
						Original	Balance				
Name of Lender	Related** YES NO		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
<b>A. Directly Facility Related</b>											
<b>Long-Term</b>											
1						\$	\$			\$	1
2											2
3			This page not applicable								3
4											4
5											5
<b>Working Capital</b>											
6											6
7											7
8											8
9	<b>TOTAL Facility Related</b>					\$	\$			\$	9
<b>B. Non-Facility Related*</b>											
10											10
11											11
12											12
13											13
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$	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.) SEE ACCOUNTANTS' COMPILATION REPORT

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions,

**2002 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 Ben Perkins, Administrator

TELEPHONE (309) 389-2338 FAX #: (309) 289-8384

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

Enter the tax index number and real estate tax assessed for 2002 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 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u>County home does not</u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u>pay real estate tax.</u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		<b>TOTALS</b>	\$ <u></u>	\$ <u></u>

**B. Real Estate Tax Cost Allocation:**

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 & 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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

See Accountants' Compilation Report

Facility Name & ID Number Knox County Nursing Home# 0010561 Report Period Beginning:12/01/2002 Ending:11/30/2003

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 100,375 B. General Construction Type: Exterior Brick Frame Steel Number of Stories OneC. Does the Operating Entity?  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (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 ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/AF. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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: N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>1,481,040</u>	<u>1966</u>	<u>\$ 156,600</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<u>1,481,040</u>		<u>\$ 156,600</u>	<u>3</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/2002 Ending: 11/30/2003

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	204	1966	1966	\$ 1,842,192	\$ 36,844	50	\$ 36,844	\$	\$ 1,372,516	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	1966 Land Improvements		1966	46,724	934	50	934		33,987	9
10	1971 Additions		1971	152,822		20			152,822	10
11	1980 Additions		1980	15,242		20			15,242	11
12	1981 Additions		1981	650		20			650	12
13	1983 Additions		1983	14,762	164	20	164		14,762	13
14	1984 Additions		1984	31,009	771	20	771		28,462	14
15	1985 Additions		1985	106,261	4,078	20	4,078		101,672	15
16	1986 Additions		1986	141,506	849	20	849		141,506	16
17	1987 Additions		1987	143,424	5,296	15	5,296		143,424	17
18	1988 Additions		1988	69,882	3,017	20	3,017		48,992	18
19	1989 Additions		1989	37,676	2,380	15	2,380		34,037	19
20	1990 Additions		1990	29,117	1,287	20	1,287		17,240	20
21	1991 Additions		1991	175,965	10,590	15	10,590		144,266	21
22	1992 Additions		1992	232,540	15,334	15	15,334		176,304	22
23	1993 Additions		1993	43,687	3,091	15	3,091		36,474	23
24	1994 Additions		1994	115,370	7,700	15	7,700		76,382	24
25	1995 Additions		1995	68,274	4,618	15	4,618		49,749	25
26	1996 Additions		1996	82,777	5,378	15	5,378		47,472	26
27	1997 Additions		1997	37,834	3,408	15	3,408		22,018	27
28	Bed Lights		1998	3,524	352	10	352		2,055	28
29	Parts for call system		1998	450	45	10	45		225	29
30	Fish Pond		1998	2,629	175	15	175		963	30
31	Garage Door		1998	1,110	74	15	74		419	31
32	Door alarm equipment		1998	596	60	10	60		339	32
33	Fire eye controls		1998	1,110	74	15	74		419	33
34	Fire eye controls		1998	545	36	15	36		199	34
35	Chiller Improvements		1998	1,503	100	15	100		1,361	35
36			1998	5,217	348	15	348		1,768	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/2002 Ending: 11/30/2003

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Oil pump for compressor	1998	\$ 676	\$ 45	15	\$ 45	\$	\$ 627		37
38	New pumps	1998	1,298	87	15	87		1,213		38
39	Boiler improvements	1998	3,195	213	15	213		1,065		39
40	Boiler repairs	1998	475	32	15	32		180		40
41	Install fire eye	1998	182	12	15	12		68		41
42	Hot water storage tank	1998	11,904	595	20	595		3,124		42
43	Plumbing upgrades	1998	4,286	214	20	214		1,107		43
44	Compressor improvement	1998	1,333	89	15	89		459		44
45	Coil replacement	1998	1,048	70	15	70		361		45
46	Laundry room ventilation	1999	3,246	216	15	216		1,180		46
47	Steam generated tanks	1999	13,865	924	15	924		5,044		47
48	Pump	1999	924	92	10	92		2,819		48
49	Air conditioner	1999	2,476	248	10	248		991		49
50	Freezer compressor	2000	2,321	232	10	232		890		50
51	Air conditioner	2000	2,810	281	10	281		913		51
52	Exhaust Fan	2000	1,500	150	10	150		463		52
53	Hot water heater	2000	13,865	1,387	10	1,387		5,547		53
54	Fireplace	2001	1,395	140	10	140		292		54
55										55
56	Architect fees - Boiler work	2003	11,412	285	20	285		285		56
57	Boiler replacement & upgrade	2003	80,229	2,006	20	2,006		2,006		57
58	Asbestos inspections	2003	9,825	275	20	275		275		58
59	Architect - Toilet & bathing rooms	2003	1,916	54	20	54		54		59
60	Framing, drywall, plumbing, finishing - Handicap bathrooms	2003	26,549	743	20	743		743		60
61	Bathroom fixtures, hand rails	2003	3,819	191	10	191		191		61
62	Tub	2003	3,895	195	10	195		195		62
63	Architect - Hospice wing	2003	4,480	112	20	112		112		63
64										64
65	Hospice - Minor renovation, drywall, wall coverings	2003	8,182	205	20	205		205		65
66	Wall coverings, drywall, minor renovation	2003	10,264	257	20	257		257		66
67	Garden room doors	2003	1,691	42	20	42		42		67
68	Unreconciled difference							(2,450)		68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,633,459	\$ 116,395		\$ 116,395	\$	\$ 2,693,983		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 431,368	\$ 32,353	\$ 32,353	\$	10-15	\$ 208,491	71
72	Current Year Purchases	145,975	11,934	11,934		5-10	11,934	72
73	Fully Depreciated Assets	327,648					327,648	73
74								74
75	TOTALS	\$ 904,991	\$ 44,287	\$ 44,287	\$		\$ 548,073	75

D. Vehicle Depreciation (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	Resident care	Van	1992	\$ 38,295	\$	\$	\$	4	\$ 38,295	76
77	Resident care	Ford Escort Wagon	1993	10,827				4	10,827	77
78	Resident care	Ford Truck	1995	17,024				4	17,024	78
79										79
80	TOTALS			\$ 66,146	\$	\$	\$		\$ 66,146	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)	\$ 4,761,196	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 160,682	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 160,682	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,308,202	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

**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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions			<u>N/A</u>			4
5							5
6							6
7	<b>TOTAL</b>			\$			7

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.	<u>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</u>	\$ _____

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: \_\_\_\_\_ \*

**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: \$ 2,519 Description: Dish washer - 2519  
 (Attach a schedule detailing the breakdown of movable equipment)

\* 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.

**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			<u>N/A</u>		18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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	Nurse Aide Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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 aide 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 aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost					
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,639	\$	54,581				3,639	\$	54,581	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,106		31,586				2,106		31,586	2	
3	Licensed Recreational Therapist		hrs											3	
4	Licensed Physical Therapist	10A(3)	hrs		4,409		66,131				4,409		66,131	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 prescripts							282,857			282,857	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10	
11	Academic Education		hrs											11	
12	Exceptional Care Program	39(1,2,3)	1040		22,350		950		14,245	11,350	1,990		47,945	12	
13	Other (specify):													13	
14	<b>TOTAL</b>			\$	22,350		11,104	\$	166,543	\$	294,207	12,144	\$	483,100	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

**Knox County Nursing Home**  
**Provider #: 0010561**  
**12/01/2002 to 11/30/2003**

Schedule 16A

XIV. Special Services  
Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
	L39, C3			
Total			<u>0</u>	<u>0</u>

**See Accountants' Compilation Report**

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Knox County Nursing Home

# 0010561

Report Period Beginning: 12/01/2002

Ending:

11/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 957,756	\$ 957,756	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>none</u> )	1,423,524	1,423,524	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,113	15,113	6
7	Other Prepaid Expenses	73,607	73,607	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,470,000	\$ 2,470,000	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	65,497	65,497	12
13	Land	156,600	156,600	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	3,342,242	3,633,459	15
16	Equipment, at Historical Cost	917,868	971,137	16
17	Accumulated Depreciation (book methods)	(3,303,495)	(3,308,202)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,178,712	\$ 1,518,491	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,648,712	\$ 3,988,491	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 234,993	\$ 234,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	228,762	228,762	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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to other funds</u>	15,495	15,495	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 479,250	\$ 479,250	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 479,250	\$ 479,250	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,169,462	\$ 3,509,241	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,648,712	\$ 3,988,491	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,765,265</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Adjustments subsequent to prior year cost report</b>	<b>(91,963)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,673,302</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>496,160</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>496,160</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,169,462</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Knox County Nursing Home

# 0010561

Report Period Beginning: 12/01/2002

Ending: 11/30/2003

**VII. 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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,120,753	1
2	Discounts and Allowances for all Levels	(18,679)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,102,074	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	42,213	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 42,213	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	9,643	12
13	Barber and Beauty Care	4,290	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	147,540	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	45,657	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 207,130	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	8,352	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,352	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Farm income, net of expense</b>	4,701	28
28a	<b>Tax referendum receipts</b>	562,536	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 567,237	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,927,006	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,945,305	31
32	Health Care	3,804,638	32
33	General Administration	1,040,956	33
<b>B. Capital Expense</b>			
34	Ownership	147,719	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	380,436	35
36	Provider Participation Fee	111,792	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,430,846	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	496,160	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 496,160	43

\* 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. Files as part of County return.

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

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

Facility Name & ID Number Knox County Nursing Home

# 0010561

Report Period Beginning: 12/01/2002

Ending: 11/30/2003

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	2,080	2,080	\$ 69,988	\$ 33.65	1
2	Assistant Director of Nursing	2,080	2,080	51,590	24.80	2
3	Registered Nurses	19,525	19,525	405,960	20.79	3
4	Licensed Practical Nurses	38,502	38,502	618,144	16.05	4
5	Nurse Aides & Orderlies	166,222	166,222	1,865,689	11.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,817	8,817	97,836	11.10	10
11	Social Service Workers	7,289	7,289	143,923	19.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	42,772	42,772	381,972	8.93	15
16	Dishwashers					16
17	Maintenance Workers	8,512	8,512	122,455	14.39	17
18	Housekeepers	26,498	26,498	239,742	9.05	18
19	Laundry	16,051	16,051	139,234	8.67	19
20	Administrator	2,080	2,080	79,798	38.36	20
21	Assistant Administrator	750	750	17,479	23.31	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,203	12,203	158,442	12.98	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	1,935	1,935	18,404	9.51	31
32	Other Health C <sub>2</sub> (See Sch 20A)	7,148	7,148	123,088	17.22	32
33	Other(specify) (See Sch 20A)	2,038	2,038	18,301	8.98	33
34	TOTAL (lines 1 - 33)	364,502	364,502	\$ 4,552,045 *	\$ 12.49	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	229	\$ 8,693	1(3)	35
36	Medical Director	Monthly	7,195	9(3)	36
37	Medical Records Consultant	16	1,500	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	12,980	10(3)	39
40	Physical Therapy Consultant	132	6,513	10A(3)	40
41	Occupational Therapy Consultant	46	2,104	10A(3)	41
42	Respiratory Therapy Consultant	1	70	10A(3)	42
43	Speech Therapy Consultant	7	340	10A(3)	43
44	Activity Consultant	42	2,296	11(3)	44
45	Social Service Consultant	42	2,296	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	563	\$ 43,987		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses	None		51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Knox County Nursing Home  
 Provider #: 0010561  
 12/01/2002 to 11/30/2003

Schedule 20 A

**Other Health Care - Line 32**

Title	Hours	Hours	Average	
	Worked	Paid	Wages	Hrly Wage
Care Plan Coordinator	2,080	2,080	41,533	19.97
Medicare Coordinator	2,080	2,080	41,722	20.06
Exceptional Care Nursing	1,040	1,040	22,350	21.49
Transportation	1,948	1,948	17,483	8.97
	<u>7,148</u>	<u>7,148</u>	<u>123,088</u>	<u>17.22</u>

**Other - Line 33**

Title	Hours	Hours	Average	
	Worked	Paid	Wages	Hrly Wage
Beautician	2,038	2,038	18,301	8.98
	<u>2,038</u>	<u>2,038</u>	<u>18,301</u>	<u>8.98</u>

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function			Description	Amount	Description	Amount	Description	Amount
Ben Perkins	Administrator	0	\$ 79,798	Workers' Compensation Insurance	\$ 95,268	IDPH License Fee	\$		
Shannon Minshall	Asst. Administrator	0	17,479	Unemployment Compensation Insurance	28,276	Advertising: Employee Recruitment	3,019		
				FICA Taxes	384,497	Health Care Worker Background Check (Indicate # of checks performed 149)	1,788		
				Employee Health Insurance	460,170	Illinois Health Care Association dues	10,988		
				Employee Meals	17,690	County Nursing Home Association dues	2,040		
				Illinois Municipal Retirement Fund (IMRF)*	146,743	NAEIR	1,806		
				Uniforms	29,340	Miscellaneous dues & subscriptions	382		
				Employee Morale	648	Medical publications & forms	2,025		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 97,277					
B. Administrative - Other									
Description				Amount					
N/A									
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$					
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Miller, Tracy, Braun, LTD.	Legal		6,240				Out-of-State Travel	\$	
States Atty Appellate Pros.	Legal		15						
Altschuler, Melvoin & Glasser	Accounting		14,599				In-State Travel	301	
BKD	Accounting		4,502	N/A					
Blucker, Kneer Associates	Accounting		5,250				Seminar Expense	1,469	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$ 30,606	TOTAL	\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,770	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Knox County Nursing Home**  
**Provider #: 0010561**  
**12/01/2002 to 11/30/2003**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

**Total (agree to Schedule V, line 19, column 3)** 30,606

**Less: Non-allowable out-of-period costs** (2,764)

**Total (agree to Schedule V, line 19, column 8)** 27,842

**See Accountants' Compilation Report**

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

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
2			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3														
4	N/A													
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home# 0010561Report Period Beginning: 12/01/2002 Ending: 11/30/2003

## 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? Yes  
If YES, give association name and amount. IHCA - 10,988; IL County NH Assn - 2,040
- (3) Did the nursing home make political contributions or payments to a political 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? 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 58,177 Line 10(2)
- (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 of Public Aid during this cost report period. \$ 111,792  
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 of Public Aid, 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 benefit: on Schedule V. \$ 17,690 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? 0%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**  
**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: Blucker, Kneer & Assoc. LTD The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

**Knox County Nursing Home**

**Provider #: 0010561 0010561**

**12/01/2002 to 11/30/2003**

**Page 3: Schedule V - Line 23 - Inservice Training**

In-house training on Achieve Software	27,504
Training tapes and manuals from various vendors	3,743
Home study for Beautician	125

<b>Total (agree to Schedule V, line 23, column 3)</b>	<b><u><u>31,372</u></u></b>
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RECONCILIATION REPORT

Knox County Nursing Home 12:16 PM 11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	340,916	equal to	340,916	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	160,682	equal to	160,682	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,519	equal to	2,519	0	O.K.	Pg14 J30+N40	B. + C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	22,350	equal to	22,350	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	161,325	equal to	161,325	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	294,207	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,945,305	equal to	1,945,305	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,804,638	equal to	3,804,638	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	1,040,956	equal to	1,040,956	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	147,719	equal to	147,719	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	380,436	equal to	380,436	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38b41+43	4
Income Stat. Prov. Partic.	111,792	equal to	111,792	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,029,775	equal to	3,113,030	-83,255	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	22,350	-22,350	FAILED	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	97,836	equal to	97,836	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	143,923	equal to	143,923	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	381,972	equal to	381,972	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	122,455	equal to	122,455	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	239,742	equal to	239,742	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	139,234	equal to	139,234	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	97,277	equal to	97,277	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	158,442	equal to	158,442	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,552,045	equal to	4,552,045	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	8,693	< or = to	8,693	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	7,195	< or = to	7,195	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	14,480	< or = to	23,559	-9,079	O.K.	Pg20 X14..X16+	B. & C.	37b39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,296	< or = to	2,296	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,296	< or = to	2,296	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	97,277	equal to	97,277	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	30,606	equal to	30,606	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	1,162,632	equal to	1,162,632	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	22,048	equal to	22,048	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,770	equal to	1,770	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	111,792	equal to	111,792	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	17,690	< or = to	522,282	-504,592	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	17,690	equal to	17,690	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	3,969	equal to	4,114	-145	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	545,880	equal to	545,880	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4f	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	156,600	equal to	156,600	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,633,459	equal to	3,633,459	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	971,137	equal to	971,137	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	3,308,202	equal to	3,308,202	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,169,462	equal to	3,169,462	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	496,160	equal to	496,160	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,648,712	equal to	3,648,712	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

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	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	381,972	29,724	8,693	420,389	0	420,389	0	420,389
2. Food Purchase	0	334,547	0	334,547	0	334,547	0	334,547
3. Housekeeping	239,742	45,941	0	285,683	0	285,683	0	285,683
4. Laundry	139,234	33,767	72,469	245,470	0	245,470	0	245,470
5. Heat and Other Utilities	0	0	232,826	232,826	0	232,826	0	232,826
6. Maintenance	122,455	4,220	299,715	426,390	0	426,390	-193,731	232,659
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	883,403	448,199	613,703	1,945,305	0	1,945,305	-193,731	1,751,574
9. Medical Director	0	0	7,195	7,195	0	7,195	0	7,195
10. Nursing & Medical Records	3,113,030	226,787	23,559	3,363,376	0	3,363,376	0	3,363,376
10a. Therapy	0	0	161,325	161,325	0	161,325	0	161,325
11. Activities	97,836	8,316	2,296	108,448	0	108,448	0	108,448
12. Social Services	143,923	592	2,296	146,811	0	146,811	0	146,811
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	17,483	0	0	17,483	0	17,483	0	17,483
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,372,272	235,695	196,671	3,804,638	0	3,804,638	0	3,804,638
17. Administrative	97,277	0	0	97,277	0	97,277	0	97,277
18. Directors Fees	0	0	2,371	2,371	0	2,371	0	2,371
19. Professional Services	0	0	30,606	30,606	0	30,606	-2,764	27,842
20. Fees, Subscriptions & Promotion	0	0	22,048	22,048	0	22,048	0	22,048
21. Clerical & General Office	158,442	11,254	30,116	199,812	0	199,812	20,904	220,716
22. Employee Benefits & Payroll	0	0	640,350	640,350	0	640,350	522,282	1,162,632
23. Inservice Training & Education	0	0	31,372	31,372	0	31,372	0	31,372
24. Travel and Seminar	0	0	1,770	1,770	0	1,770	0	1,770
25. Other Admin. Staff Trans	0	0	5,078	5,078	0	5,078	0	5,078
26. Insurance-Prop.Liab.Malpractice	0	0	10,272	10,272	0	10,272	0	10,272
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	255,719	11,254	773,983	1,040,956	0	1,040,956	540,422	1,581,378
29. Total General Administrative	4,511,394	695,148	1,584,357	6,790,899	0	6,790,899	346,691	7,137,590
30. Depreciation	0	0	145,200	145,200	0	145,200	15,482	160,682
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	2,519	2,519	0	2,519	0	2,519
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	147,719	147,719	0	147,719	15,482	163,201
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	22,350	294,207	14,245	330,802	0	330,802	0	330,802
40. Barber and Beauty Shop	18,301	1,558	0	19,859	0	19,859	0	19,859
41. Coffee and Gift Shops	0	0	8,518	8,518	0	8,518	0	8,518
42	0	0	111,792	111,792	0	111,792	0	111,792
43. Other (specify):*	0	0	21,257	21,257	0	21,257	-21,257	0
44. Total Special Cost Ce	40,651	295,765	155,812	492,228	0	492,228	-21,257	470,971
45. Grand Total	4,552,045	990,913	1,887,888	7,430,846	0	7,430,846	340,916	7,771,762

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	957,756	957,756
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	1,423,524	1,423,524
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	15,113	15,113
7. Other Prepaid Expenses	73,607	73,607
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,470,000	2,470,000
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	65,497	65,497
13. Land	0	0
14. Buildings, at Historical Cost	0	0
15. Leasehold Improvements, Historical Cost	4,416,710	4,761,196
16. Equipment, at Historical Cost	0	0
17. Accumulated Depreciation (book methods)	-3,303,495	-3,308,202
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,178,712	1,518,491
25. Total Assets	3,648,712	3,988,491
CURRENT LIABILITIES		
26. Accounts Payable	234,993	234,993
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	228,762	228,762
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	15,495	15,495
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	479,250	479,250
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	0
46. Total Liabilities	479,250	479,250
47. Total Equity	3,094,825	3,509,241
48. Total Liabilities and Equity	3,574,075	3,988,491

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,120,753
2. Discounts and Allowances for all Levels	-18,679
Subtotal - Inpatient Care	7,102,074
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	42,213
Subtotal - Ancillary Revenue	42,213
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	9,643
13. Barber and Beauty Care	4,290
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	147,540
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	45,657
22. Laundry	0
Subtotal - Other Operating Revenue	207,130
24. Contributions	0
25. Interest and Other Investments Income	8,352
Subtotal - Non-Operating Revenue	8,352
27. Other Revenue (specify):	4,701
28. Other Revenue (specify):	562,536
Subtotal - Other Revenue	567,237
30. Total Revenue	7,927,006
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	5,177,390
42. Income Taxes	0
43. Net Income or Loss for the Year	5,177,390

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- 23 Provider Participation fee is linked from page 4