

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0010561

Facility Name: Knox County Nursing Home

Address: 800 North Market Street Knoxville 61448
 Number City Zip Code

County: Knox

Telephone Number: (309)289-2338 **Fax #** (309)289-8255

HFS ID Number: 376001167801

Date of Initial License for Current Owners: 10/23/46

Type of Ownership:

<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
IRS Exemption Code _____	<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 _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/05 to 11/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Andrew B. Cutler</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561 Report Period Beginning: 12/01/05 Ending: 11/30/06

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	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	8,211	3,679	3,101	14,991	8
9	SNF/PED					9
10	ICF	23,475	8,735	2,525	34,735	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,686	12,414	5,626	49,726	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.78%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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 _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 204 and days of care provided 2,635

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30/2006 Fiscal Year: 11/30/2006

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/05 Ending: 11/30/06

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

	Operating Expenses	Costs 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
	A. General Services										
1	Dietary	306,097	27,048	10,440	343,585		343,585	343,585			1
2	Food Purchase		291,372		291,372		291,372	291,372			2
3	Housekeeping	208,882	31,210		240,092		240,092	240,092			3
4	Laundry	65,327	15,457	96,519	177,303		177,303	177,303			4
5	Heat and Other Utilities			236,011	236,011		236,011	(3,147)	232,864		5
6	Maintenance	122,156	1,963	63,708	187,827		187,827	(4,588)	183,239		6
7	Other (specify):*										7
8	TOTAL General Services	702,462	367,050	406,678	1,476,190		1,476,190	(7,735)	1,468,455		8
	B. Health Care and Programs										
9	Medical Director			7,000	7,000		7,000	7,000			9
10	Nursing and Medical Records	2,775,628	165,838	16,116	2,957,582		2,957,582	2,957,582			10
10a	Therapy			6,562	6,562		6,562	6,562			10a
11	Activities	84,860		2,293	87,153		87,153	87,153			11
12	Social Services	105,104	6,206	2,293	113,603		113,603	113,603			12
13	CNA Training										13
14	Program Transportation	19,359			19,359		19,359	19,359			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,984,951	172,044	34,264	3,191,259		3,191,259	3,191,259			16
	C. General Administration										
17	Administrative	78,789			78,789		78,789	78,789			17
18	Directors Fees										18
19	Professional Services			27,904	27,904		27,904	(1,668)	26,236		19
20	Dues, Fees, Subscriptions & Promotions			12,638	12,638		12,638	12,638			20
21	Clerical & General Office Expenses	152,513	13,206	150,659	316,378		316,378	(96,468)	219,910		21
22	Employee Benefits & Payroll Taxes			519,723	519,723		519,723	691,306	1,211,029		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,548	4,548		4,548	4,548			24
25	Other Admin. Staff Transportation			10,126	10,126		10,126	(33)	10,093		25
26	Insurance-Prop.Liab.Malpractice			16,617	16,617		16,617	16,617			26
27	Other (specify):*										27
28	TOTAL General Administration	231,302	13,206	742,215	986,723		986,723	593,137	1,579,860		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,918,715	552,300	1,183,157	5,654,172		5,654,172	585,402	6,239,574		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.

Facility Name & ID Number Knox County Nursing Home #0010561 Report Period Beginning: 12/01/05 Ending: 11/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			245,660	245,660	245,660	1,067	246,727				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			643	643	643	(643)					32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,581	7,581	7,581		7,581				35
36	Other (specify):*											36
37	TOTAL Ownership			253,884	253,884	253,884	424	254,308				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		312,891		312,891	312,891		312,891				39
40	Barber and Beauty Shops	17,078		817	17,895	17,895		17,895				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690	111,690		111,690				42
43	Other (specify):*			839	839	839	(839)					43
44	TOTAL Special Cost Centers	17,078	312,891	113,346	443,315	443,315	(839)	442,476				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,935,793	865,191	1,550,387	6,351,371	6,351,371	584,987	6,936,358				45

*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

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

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	(3,147)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,067	30		9
10	Interest and Other Investment Income	(643)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		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	(7,300)	21		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	(102,931)	21		24
25	Fund Raising, Advertising and Promotional				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	(14,031)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (126,985)		\$	30

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)	711,972		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 711,972		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 584,987		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Burn Income	\$ (839)	43	1
2 Bank Charges	(161)	21	2
3 Marketing Services	(6,742)	21	3
4 Capitalized R&M	(4,588)	06	4
5 Out of State Travel	(33)	23	5
6 Non-Allowable Legal	(1,668)	19	6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
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92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(14,031)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

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													1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,147)											(3,147)	5
6	Maintenance	(4,588)											(4,588)	6
7	Other (specify):*													7
8	TOTAL General Services	(7,735)											(7,735)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(1,668)											(1,668)	19
20	Fees, Subscriptions & Promotions													20
21	Clerical & General Office Expenses	(117,134)	20,666										(96,468)	21
22	Employee Benefits & Payroll Taxes		691,306										691,306	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation	(33)											(33)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(118,835)	711,972										593,137	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(126,570)	711,972										585,402	29

STATE OF ILLINOIS

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05 Ending:

Summary B

11/30/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	1,067											1,067	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(643)											(643)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	424											424	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(839)											(839)	43
44	TOTAL Special Cost Centers	(839)											(839)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(126,985)	711,972										584,987	45

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

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
<u>Knox County</u>	<u>100%</u>	<u>None</u>		<u>None</u>		

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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
<u>1</u>	<u>V</u>	<u>22</u>	<u>Employee Benefits IMRF</u>	<u>\$</u>	<u>Knox County</u>	<u>100.00%</u>	<u>\$ 377,977</u>	<u>\$ 377,977</u>	<u>1</u>
<u>2</u>	<u>V</u>	<u>22</u>	<u>Employee Benefits FICA</u>		<u>Knox County</u>	<u>100.00%</u>	<u>313,329</u>	<u>313,329</u>	<u>2</u>
<u>3</u>	<u>V</u>	<u>21</u>	<u>Bookkeeping & Accounting</u>		<u>Knox County</u>	<u>100.00%</u>	<u>20,666</u>	<u>20,666</u>	<u>3</u>
<u>4</u>	<u>V</u>								<u>4</u>
<u>5</u>	<u>V</u>								<u>5</u>
<u>6</u>	<u>V</u>								<u>6</u>
<u>7</u>	<u>V</u>								<u>7</u>
<u>8</u>	<u>V</u>								<u>8</u>
<u>9</u>	<u>V</u>								<u>9</u>
<u>10</u>	<u>V</u>								<u>10</u>
<u>11</u>	<u>V</u>								<u>11</u>
<u>12</u>	<u>V</u>								<u>12</u>
<u>13</u>	<u>V</u>								<u>13</u>
<u>14</u>	Total		\$			\$ 711,972	\$ *	711,972	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/05 Ending: 11/30/06

VII. RELATED PARTIES (continued)

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)	
15	V								15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* 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: 12/01/05 Ending: 11/30/06

VII. RELATED PARTIES (continued)

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)	
15	V								15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V								15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/05 Ending: 11/30/06

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	County No Longer Holds Committee Meetings Relating Only To The Nursing Home. All County Meetings Relate To The County								\$		1	
2	As A Whole. Therefore, Per Diems and Mileage Are Not Separately Paid By The Nursing Home.											2
3											3	
4											4	
5											5	
6											6	
7											7	
8											8	
9											9	
10	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											10
11	Conducted Business Transactions With The Nursing Home During The Reporting Period.											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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending: 11/30/06

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 South Cherry Street
 City / State / Zip Code Galesburg, Illinois 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	22	Employee Benefits IMRF	Direct Cost	1	1	\$	\$	1	\$ 377,977	1
2	22	Employee Benefits FICA	Direct Cost	1	1			1	313,329	2
3	21	Bookkeeping & Accounting	Hours Worked	1,716	1716	20,666		1,716	20,666	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					\$ 20,666	\$		\$ 711,972	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning: 12/01/05

Ending: 11/30/06

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
 Fax Number (_____) _____

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									1
2									2
3									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending: 11/30/06

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
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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									1
2									2
3									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending: 11/30/06

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
 Fax Number (_____) _____

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									1
2									2
3									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending: 11/30/06

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending: 11/30/06

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending: 11/30/06

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending: 11/30/06

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending: 11/30/06

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending: 11/30/06

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	1
2									2
3									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Office Specialists, Inc.		X	Copier	\$243.41	09/2004	\$ 12,678	\$ 7,756	09/2009	0.0571	\$ 643	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6												6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				\$243.41		\$ 12,678	\$ 7,756			\$ 643	9
	B. Non-Facility Related*											
10	Interest Income		X								(643)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(643)	14
15	TOTALS (line 9+line14)						\$ 12,678	\$ 7,756			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

Facility Name & ID Number

Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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						
		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						
6												6						
7	TOTAL Long-Term																	
	Working Capital																	
8							\$	\$			\$	8						
9												9						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital																	
	B. Non-Facility Related*																	
15							\$	\$			\$	15						
16												16						
17												17						
18												18						
19												19						
20	TOTAL Non-Facility Related																	

* 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2006 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:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	12		
Facility Does Not Pay Real Estate Taxes				
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2005	\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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, please call the Bureau of Health Finance at (217) 782-1630.

2005 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 Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>N/A</u>	<u>\$ N/A</u>	<u>\$ N/A</u>
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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 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 2001 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, please call the Office of Health Finance at (217) 782-1630.

2000 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 Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(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. _____	_____	\$ _____	\$ _____
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 & 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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Knox County Nursing Home

0010561 Report Period Beginning:

12/01/05 Ending:

11/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 100,375 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (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 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).

N/A

F. 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: _____
(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>Facility</u>	<u>1,481,040</u>	<u>1966</u>	<u>\$ 156,600</u>	1
2					2
3	TOTALS	1,481,040		\$ 156,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	204		1966	1966	\$ 1,842,192	\$	50	\$ 36,844	\$ 36,844	\$ 1,483,048	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various		1966		46,724		20	934	934	36,790	9
10	Various		1971		146,065		20			146,065	10
11	Various		1980		9,972		20			9,972	11
12	Various		1981		650		20			650	12
13	Various		1983		14,762		20			14,762	13
14	Various		1984		31,009		20	226	226	31,009	14
15	Various		1985		73,090		20			73,090	15
16	Various		1986		141,506		20			141,506	16
17	Various		1987		142,693		20			142,693	17
18	Various		1988		60,820		20	3,041	3,041	58,091	18
19	Various		1989		47,469		20	3,165	3,165	42,746	19
20	Various		1990		29,117		20	1,456	1,456	21,439	20
21	Various		1991		17,547		20			17,547	21
22	Various		1992		197,932		20			197,932	22
23	Various		1993		97,234		20	6,482	6,482	52,530	23
24	Various		1994		45,232		20			45,232	24
25	Various		1995		58,215		20			58,215	25
26	Various		1996		76,390		20	5,093	5,093	63,035	26
27	Various		1997		26,377		20			26,377	27
28	Various		1998		39,334		20	2,134	2,134	22,992	28
29	Various		1999		21,237		20	1,437	1,437	12,493	29
30	Various		2000		20,496		20	2,050	2,050	13,963	30
31	Various		2001		1,395		20	140	140	712	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69					245,660		(245,660)	69
70		\$ 3,187,458	\$ 245,660		\$ 63,002	\$ (182,658)	\$ 2,712,889	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

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	
1	Totals from Page 12A, Carried Forward		\$ 3,187,458	\$ 245,660		\$ 63,002	\$ (182,658)	\$ 2,712,889	1
2	Architect Fees - Boiler Work	2003	11,412		20	571	571	1,997	2
3	Boiler Replacement & Upgrade	2003	80,229		20	4,011	4,011	14,040	3
4	Asbestos Inspections	2003	9,825		20	491	491	1,749	4
5	Architect - Toilet & Bathing Rooms	2003	1,916		20	96	96	342	5
6	Framing, Drywall, Plumbing, Finishing - Handicap Bathrooms	2003	26,549		20	1,327	1,327	4,725	6
7	Bathroom Fixtures, Hand Rails	2003	3,819		20	382	382	1,337	7
8	Tub	2003	3,895		20	390	390	1,365	8
9	Architect - Hospice Wing	2003	4,480		20	224	224	784	9
10	Hospice - Minor Renovation, Drywall, Wall Coverings	2003	5,256		20	263	263	1,140	10
11	Wall Coverings, Drywall, Minor Renovation	2003	10,264		20	513	513	1,796	11
12	Garden Room Doors	2003	1,691		20	85	85	296	12
13	A/C Parts	2003	1,904		20	95	95	190	13
14	Door	2004	1,352		20	68	68	135	14
15	New Condensing Unit	2004	8,933		20	447	447	893	15
16	Awning	2004	431		20	22	22	43	16
17	Renovation	2004	2,168		20	108	108	217	17
18	Air Handler - Fire Alarm	2004	2,483		20	124	124	248	18
19	Renovation	2004	290		20	14	14	29	19
20	Fire Doors	2004	4,230		20	212	212	423	20
21	Fire Door Installation	2004	4,500		20	225	225	450	21
22	Hvac	2004	5,900		20	295	295	590	22
23	Freight Elevator	2004	6,029		20	301	301	603	23
24	Fire Alarm System	2004	725		20	36	36	73	24
25	Architect - Remodel Rooms	2004	22,273		20	1,114	1,114	2,784	25
26	Hospice - Minor Renovation	2004	3,379		20	169	169	422	26
27	Bathroom Upgrade	2004	3,566		20	178	178	446	27
28	Condensing Unit	2004	9,182		20	918	918	2,295	28
29	Fire Doors	2004	11,238		20	1,124	1,124	2,810	29
30	Fire Alarm	2004	1,516		20	76	76	190	30
31	Call Light Cords	2004	2,163		20	108	108	270	31
32	Door Locks	2004	2,864		20	143	143	429	32
33	Resurface Parking Lot	2004	18,167		20	908	908	1,817	33
34	TOTAL (lines 1 thru 33)		\$ 3,460,087	\$ 245,660		\$ 78,041	\$ (167,619)	\$ 2,757,817	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

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	
1	Totals from Page 12B, Carried Forward		\$ 3,460,087	\$ 245,660		\$ 78,041	\$ (167,619)	\$ 2,757,817	1
2	Architect	2004	3,224		20	161	161	322	2
3	Steam Distributing Coil	2004	1,715		20	86	86	172	3
4	Garbage Disposer	2005	1,994		20	100	100	199	4
5	Phone System	2005	2,177		20	109	109	218	5
6	Ejector Pump	2005	6,240		20	312	312	624	6
7	Smoke Dampers	2005	590		20	30	30	59	7
8	Elevator Upgrade	2005	32,880		20	1,644	1,644	3,288	8
9	Architect	2005	480		20	24	24	48	9
10	Wallcovering	2005	435		20	22	22	43	10
11	Wallcovering	2005	1,935		20	97	97	194	11
12	Flush Valve Converter	2005	636		20	32	32	64	12
13	Gauge Assembly For Boiler	2005	830		20	41	41	83	13
14	Verticle Mt Emergenchshower And Other Inv	2005	1,456		20	73	73	146	14
15	Wall Covering W 2	2005	311		20	16	16	31	15
16	Drapery	2005	3,129		20	156	156	313	16
17	Faucets	2005	3,915		20	196	196	391	17
18	Cement Fire Lane	2005	300		20	15	15	30	18
19	Signage	2005	1,634		20	82	82	163	19
20	Water Chiller	2005	549		20	27	27	55	20
21	Remodeling / Redecorating	2005	170,256		20	8,513	8,513	17,026	21
22	Cooling Tower	2005	32,196		20	1,610	1,610	3,220	22
23	Remodeling / Redecorating	2005	4,688		20	234	234	469	23
24	Smoke Detector	2005	328		20	16	16	33	24
25	Faucets W-2	2005	637		20	32	32	64	25
26	Boiler Repair	2005	1,244		20	62	62	124	26
27	Architect	2005	400		20	20	20	40	27
28	Draperies Wing 2	2005	3,095		20	155	155	310	28
29	Chiller	2005	3,202		20	160	160	320	29
30	Cabinets For Main Dining Room	2005	637		20	32	32	64	30
31	Chiller Work	2005	622		20	31	31	62	31
32	Drapes & Hardware W-2	2005	1,277		20	64	64	128	32
33	Door Alarm	2005	203		20	10	10	20	33
34	TOTAL (lines 1 thru 33)		\$ 3,743,300	\$ 245,660		\$ 92,202	\$ (153,458)	\$ 2,786,138	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

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	
1	Totals from Page 12C, Carried Forward		\$ 3,743,300	\$ 245,660		\$ 92,202	\$ (153,458)	\$ 2,786,138	1
2	Door Closers	2005	311		20	16	16	31	2
3	Chiller Work	2005	18,625		20	931	931	1,862	3
4	2 Ea Handicap Door Openers	2005	3,507		20	175	175	351	4
5	Architect	2005	960		20	48	48	96	5
6	2 Cabinets	2005	2,417		20	121	121	242	6
7	Set 4 Laminate Panels	2005	1,024		20	51	51	102	7
8	Remove And Replace Concrete	2005	600		20	30	30	60	8
9	Drapery Rods W-2	2005	344		20	17	17	34	9
10	Drapery Rods W-2	2005	324		20	16	16	32	10
11	Wiring For Outside Lights	2005	1,027		20	51	51	103	11
12	Plan Review	2005	6,000		20	300	300	600	12
13	Architect	2005	800		20	40	40	80	13
14	Oxygen Room Door	2005	349		20	17	17	35	14
15	Locks	2005	728		20	36	36	36	15
16	Emergency Electric System - Panel	2005	1,860		20	93	93	93	16
17	Emergency Electric System - Transfer Switch	2005	4,425		20	221	221	221	17
18	Oxygen Room Mechanical Exhaust	2005	4,675		20	234	234	234	18
19	Door Locks*	2006	1,400		20	70	70	70	19
20	Air Handler*	2006	685		20	34	34	34	20
21	Wall Trim*	2006	4,082		20	204	204	204	21
22	Wallcovering*	2006	4,411		20	221	221	221	22
23	Shower Tub*	2006	15,074		20	754	754	754	23
24	Fire Alarm Tamper Switches	2006	615		20	31	31	31	24
25	Smoke Detectors*	2006	3,210		20	161	161	161	25
26	Room Signs*	2006	1,090		20	55	55	55	26
27	Shower Tub*	2006	15,074		20	754	754	754	27
28	Fire Door Lock*	2006	1,711		20	86	86	86	28
29	Wing 4 Wall Covering-Trim	2006	2,008		20	100	100	100	29
30	Sprinkers, Sprinkler Heads And Caulking	2006	896		20	45	45	45	30
31	New Fire Alarm Panel And Remote Annunciator*	2006	4,850		20	243	243	243	31
32	Smoke Detectors*	2006	3,210		20	161	161	161	32
33	Fire Dampers*	2006	1,425		20	71	71	71	33
34	TOTAL (lines 1 thru 33)		\$ 3,851,017	\$ 245,660		\$ 97,588	\$ (148,072)	\$ 2,793,338	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

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	
1	Totals from Page 12D, Carried Forward		\$ 3,851,017	\$ 245,660		\$ 97,588	\$ (148,072)	\$ 2,793,338	1
2	Fire Dampers*	2006	4,400		20	220	220	220	2
3	Fire Doors*	2006	3,441		20	172	172	172	3
4	Wall Covering Wing 4	2006	3,087		20	154	154	154	4
5	Boiler Repair*	2006	2,379		20	119	119	119	5
6	Faucets*	2006	1,625		20	81	81	81	6
7	Wallpaper*	2006	1,104		20	55	55	55	7
8	Wallcovering*	2006	1,598		20	80	80	80	8
9	Drapery*	2006	3,153		20	158	158	158	9
10	Fire Door Hardware	2006	1,015		20	51	51	51	10
11	Drapery*	2006	3,156		20	158	158	158	11
12	Door Keypad System*	2006	523		20	26	26	26	12
13	Tub Room Doors - Combo Lock*	2006	681		20	34	34	34	13
14	Faucets*	2006	1,044		20	52	52	52	14
15	Repair Wing #1 Wall*	2006	3,600		20	180	180	180	15
16	Wall Covering*	2006	2,764		20	138	138	138	16
17	Pa System*	2006	1,057		20	53	53	53	17
18	Drapes Wing 3	2006	838		20	42	42	42	18
19	Main Pump*	2006	1,758		20	88	88	88	19
20	Call Light Panels	2006	668		20	33	33	33	20
21	Restroom - Wing 1*	2006	4,117		20	206	206	206	21
22	Smoke Dectectors*	2006	3,210		20	161	161	161	22
23	Smoke Dectectors*	2006	1,220		20	61	61	61	23
24	Sprinkler System	2006	35,439		20	1,772	1,772	1,772	24
25	Grab Bars, Faucets And Shower Heads Hand Rails	2006	1,080		20	54	54	54	25
26	Moulding	2006	4,941		20	247	247	247	26
27	Wall Paper Border Wing 3	2006	943		20	47	47	47	27
28	Remodel Wing 3 & 4*	2006	526,901		20	26,345	26,345	26,345	28
29	Wall Covering Wing3	2006	738		20	37	37	37	29
30	Roofing*	2006	4,623		20	231	231	231	30
31	Room Signs*	2006	1,633		20	82	82	82	31
32	Floor Expansion Joints*	2006	975		20	49	49	49	32
33	Sprinkler System	2006	46,376		20	2,319	2,319	2,319	33
34	TOTAL (lines 1 thru 33)		\$ 4,521,103	\$ 245,660		\$ 131,092	\$ (114,568)	\$ 2,826,843	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

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	
1	Totals from Page 12E, Carried Forward		\$ 4,521,103	\$ 245,660		\$ 131,092	\$ (114,568)	\$ 2,826,843	1
2	Drapes Wing 3	2006	5,821		20	291	291	291	2
3	A/C Unit	2006	600		20	30	30	30	3
4	Sprinkler System	2006	150,040		20	7,502	7,502	7,502	4
5	Tile 2 Room Wing 3	2006	755		20	38	38	38	5
6	Concrete Sidewalk Slabs Around Building	2006	2,700		20	135	135	135	6
7	Roof Top A/C Unit	2006	6,556		20	328	328	328	7
8	Faucets And Labor W-3	2006	2,142		20	107	107	107	8
9	Door Levers	2006	681		20	34	34	34	9
10	Architect Consult Lsc	2006	1,800		20	90	90	90	10
11	Sprinkler System	2006	17,019		20	851	851	851	11
12	Sprinkler System	2006	27,280		20	1,364	1,364	1,364	12
13	4 Doors Temporary Lsc Sprinkler	2006	2,056		20	103	103	103	13
14	Temporary Fire Walls	2006	656		20	33	33	33	14
15	Remove Replace Concrete Slab	2006	1,200		20	60	60	60	15
16	Installed Smoke Dect In All 4 Day Rooms	2006	1,359		20	68	68	68	16
17	Sprinkler System	2006	27,280		20	1,364	1,364	1,364	17
18	Sprinkler System	2006	17,019		20	851	851	851	18
19	Doors Lsc	2006	2,030		20	102	102	102	19
20	Doors Lsc	2006	2,145		20	107	107	107	20
21	Door Closer*	2006	2,108		20	105	105	105	21
22	Wall Covering*	2006	2,480		20	124	124	124	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)		\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

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		
1	Totals from Page 12F, Carried Forward	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529		1
2									2
3									3
4									4
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	1
2								2
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28								28
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	1
2								2
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

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		
1	Totals from Page 12I, Carried Forward	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	1	
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	1
2								2
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	34

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

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	1
2								2
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	34

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Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	1
2								2
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	1
2								2
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	34

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Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	1
2								2
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25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	34

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Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	1
2								2
3								3
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29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	34

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

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	1
2								2
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29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,794,830	\$ 245,660		\$ 144,778	\$ (100,882)	\$ 2,840,529	34

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

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
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28											28
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30											30
31											31
32											32
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35											35
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SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
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64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Knox County Nursing Home**

0010561

Report Period Beginning:

12/01/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
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

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	\$ 777,451	\$	\$ 77,724	\$ 77,724	10	\$ 424,655	71
72	Current Year Purchases	85,380		8,538	8,538	10	8,538	72
73	Fully Depreciated Assets	327,648				10	327,648	73
74								74
75	TOTALS	\$ 1,190,479	\$	\$ 86,262	\$ 86,262		\$ 760,841	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	Facility	Ford Escort Wagon	1993	\$ 10,827	\$	\$	\$	5	\$ 10,827	76
77	Facility	Ford Truck	1995	17,024				5	17,024	77
78	Facility	VAN	2005	43,984		8,797	8,797	5	17,593	78
79	Facility	VAN	2005	34,452		6,890	6,890	5	13,781	79
80	TOTALS			\$ 106,287	\$	\$ 15,687	\$ 15,687		\$ 59,225	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)	\$ 6,248,195	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 245,660	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 246,727	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,067	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,660,595	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 7,581 Description: See Attached Schedule

(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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost												
1	Licensed Occupational Therapist	39 - 02	hrs	\$		\$		\$	175,195		\$	175,195	1			
2	Licensed Speech and Language Development Therapist		hrs										2			
3	Licensed Recreational Therapist		hrs										3			
4	Licensed Physical Therapist		hrs										4			
5	Physician Care		visits										5			
6	Dental Care		visits										6			
7	Work Related Program		hrs										7			
8	Habilitation		hrs										8			
9	Pharmacy	39 - 02	# of prescripts						121,915			121,915	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10			
11	Academic Education		hrs										11			
12	Exceptional Care Program												12			
13	Other (specify): See Supplemental								15,781			15,781	13			
14	TOTAL			\$		\$		\$	312,891		\$	312,891	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home# 0010561Report Period Beginning: 12/01/05

Ending:

11/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/06

(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	\$ 171,284	\$	1
2	Cash-Patient Deposits	19,386		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	261,756		3
4	Supply Inventory (priced at)	47,577		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 500,003	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	51,657		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	6,095,396		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(3,750,315)		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): See Attached Schedule	889,942		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,286,680	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,786,683	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 168,356	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,780		28
29	Short-Term Notes Payable	7,756		29
30	Accrued Salaries Payable	383,884		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 577,776	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 577,776	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,208,907	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,786,683	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,311,268	1
2	Restatements (describe):		2
3	Audit Adjustments to Revenue and Expenses	(437,220)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,874,048	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	334,859	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)	\$ 334,859	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,208,907	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning: 12/01/05

Ending: 11/30/06

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,013,468	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,013,468	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	53,041	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 53,041	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	619,721	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 619,721	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,686,230	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,476,190	31
32	Health Care	3,191,259	32
33	General Administration	986,723	33
B. Capital Expense			
34	Ownership	253,884	34
C. Ancillary Expense			
35	Special Cost Centers	331,625	35
36	Provider Participation Fee	111,690	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,351,371	40
41	Income before Income Taxes (line 30 minus line 40)**	334,859	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 334,859	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.

*** 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: 12/01/05

Ending: 11/30/06

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	1,534	2,080	\$ 59,633	\$ 28.67	1
2	Assistant Director of Nursing	1,960	2,080	54,624	26.26	2
3	Registered Nurses	11,576	14,563	305,362	20.97	3
4	Licensed Practical Nurses	39,471	45,297	743,988	16.42	4
5	CNAs & Orderlies	111,165	126,835	1,612,021	12.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,682	2,080	32,542	15.65	9
10	Activity Assistants	5,573	6,121	52,318	8.55	10
11	Social Service Workers	6,596	7,354	105,104	14.29	11
12	Dietician					12
13	Food Service Supervisor	1,928	2,080	28,079	13.50	13
14	Head Cook	1,791	2,219	25,390	11.44	14
15	Cook Helpers/Assistants	25,598	27,646	252,628	9.14	15
16	Dishwashers					16
17	Maintenance Workers	4,191	4,703	122,156	25.97	17
18	Housekeepers	18,139	20,537	208,882	10.17	18
19	Laundry	5,579	6,798	65,327	9.61	19
20	Administrator	2,062	2,080	78,789	37.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,904	8,632	152,513	17.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,497	3,497	36,437	10.42	33
34	TOTAL (lines 1 - 33)	250,246	284,602	\$ 3,935,793 *	\$ 13.83	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	275	\$ 10,440	01-03	35
36	Medical Director	Monthly	7,000	09-03	36
37	Medical Records Consultant	Monthly	4,216	10-03	37
38	Nurse Consultant	Flat Fee	5,862	10-03	38
39	Pharmacist Consultant	Monthly	6,038	10-03	39
40	Physical Therapy Consultant	64	2,947	10a-03	40
41	Occupational Therapy Consultant	20	928	10a-03	41
42	Respiratory Therapy Consultant	34	2,525	10a-03	42
43	Speech Therapy Consultant	3	162	10a-03	43
44	Activity Consultant	42	2,293	11-03	44
45	Social Service Consultant	42	2,293	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	480	\$ 44,704		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			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

Report Period Beginning: 12/01/05 Ending: 11/30/06

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

