

		FOR BHF USE				

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 0010561

**Facility Name:** Knox County Nursing Home

**Address:** 800 North Market 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:** 10/23/1946

**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
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**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 12/01/06 to 11/30/07 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) _____
Paid Preparer	(Type or Print Name) <u>Andrew B. Cutler</u>
	(Title) _____
Paid Preparer	(Signed) _____
	(Date) _____
	(Print Name and Title) <u>Andrew B. Cutler</u>
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; 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: 12/01/06 Ending: 11/30/07

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 09/24/07

	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)	154	69,510	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	154	69,510	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,732	2,837	3,871	14,440	8
9	SNF/PED					9
10	ICF	22,107	6,736	2,307	31,150	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,839	9,573	6,178	45,590	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.59%

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 154 and days of care provided 3,445

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: 11/30/07 Fiscal Year: 11/30/07

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/06 Ending: 11/30/07

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	336,864	35,033	9,866	381,763		381,763		381,763		1
2	Food Purchase		277,475		277,475		277,475	(21,563)	255,912		2
3	Housekeeping	204,166	31,711		235,877		235,877		235,877		3
4	Laundry	68,591	9,847	88,705	167,143		167,143		167,143		4
5	Heat and Other Utilities			236,852	236,852		236,852	(3,545)	233,307		5
6	Maintenance	120,207	1,513	81,949	203,669		203,669	(7,892)	195,777		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>729,828</b>	<b>355,579</b>	<b>417,372</b>	<b>1,502,779</b>		<b>1,502,779</b>	<b>(33,000)</b>	<b>1,469,779</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,500	9,500		9,500		9,500		9
10	Nursing and Medical Records	2,749,396	93,221	11,213	2,853,830		2,853,830		2,853,830		10
10a	Therapy		3,588	6,656	10,244		10,244		10,244		10a
11	Activities	92,538	6,590	2,605	101,733		101,733		101,733		11
12	Social Services	105,007	177	150	105,334		105,334		105,334		12
13	CNA Training										13
14	Program Transportation	14,478		4,597	19,075		19,075		19,075		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,961,419</b>	<b>103,576</b>	<b>34,721</b>	<b>3,099,716</b>		<b>3,099,716</b>		<b>3,099,716</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	80,898		2,370	83,268		83,268		83,268		17
18	Directors Fees										18
19	Professional Services			20,378	20,378		20,378	(345)	20,033		19
20	Dues, Fees, Subscriptions & Promotions			14,066	14,066		14,066		14,066		20
21	Clerical & General Office Expenses	144,984	7,141	202,744	354,869		354,869	(153,911)	200,958		21
22	Employee Benefits & Payroll Taxes			513,189	513,189		513,189	692,008	1,205,197		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,369	5,369		5,369		5,369		24
25	Other Admin. Staff Transportation			889	889		889		889		25
26	Insurance-Prop.Liab.Malpractice			12,476	12,476		12,476		12,476		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>225,882</b>	<b>7,141</b>	<b>771,481</b>	<b>1,004,504</b>		<b>1,004,504</b>	<b>537,752</b>	<b>1,542,256</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,917,129</b>	<b>466,296</b>	<b>1,223,574</b>	<b>5,606,999</b>		<b>5,606,999</b>	<b>504,752</b>	<b>6,111,751</b>		<b>29</b>

\*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: 12/01/06 Ending: 11/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			225,605	225,605	225,605	29,541	255,146			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			6,140	6,140	6,140		6,140			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			232,388	232,388	232,388	28,898	261,286			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		350,873		350,873	350,873		350,873			39
40	Barber and Beauty Shops	13,053	1,170		14,223	14,223		14,223			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			106,590	106,590	106,590		106,590			42
43	Other (specify):*			9,614	9,614	9,614	(9,614)				43
44	<b>TOTAL Special Cost Centers</b>	13,053	352,043	116,204	481,300	481,300	(9,614)	471,686			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	3,930,182	818,339	1,572,166	6,320,687	6,320,687	524,036	6,844,723			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: 12/01/06

Ending: 11/30/07

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21,563)	02		4
5	Telephone, TV & Radio in Resident Rooms	(3,545)	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	29,541	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				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	(133,630)	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	(59,314)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (189,154)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	713,190		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 713,190		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 524,036		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
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			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
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37			37
38			38
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42			42
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47			47
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78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(59,314)		101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/06

Ending:

11/30/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(21,563)											(21,563)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,545)											(3,545)	5
6	Maintenance	(7,892)											(7,892)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(33,000)</b>											<b>(33,000)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(345)											(345)	19
20	Fees, Subscriptions & Promotions													20
21	Clerical & General Office Expenses	(175,093)	21,182										(153,911)	21
22	Employee Benefits & Payroll Taxes		692,008										692,008	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	<b>(175,438)</b>	<b>713,190</b>										<b>537,752</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(208,438)</b>	<b>713,190</b>										<b>504,752</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/06

Ending:

Summary B

11/30/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	29,541											29,541	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	<b>TOTAL Ownership</b>	<b>28,898</b>											<b>28,898</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(9,614)											(9,614)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(9,614)</b>											<b>(9,614)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(189,154)</b>	<b>713,190</b>										<b>524,036</b>	<b>45</b>

Facility Name & ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/06

Ending:

11/30/07

**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>\$ 378,854</u>	<u>\$ 378,854</u>	<u>1</u>
<u>2</u>	<u>V</u>	<u>22</u>	<u>Employee Ben. Payroll Taxes</u>		<u>Knox County</u>	<u>100.00%</u>	<u>313,154</u>	<u>313,154</u>	<u>2</u>
<u>3</u>	<u>V</u>	<u>21</u>	<u>Bookkeeping &amp; Accounting</u>		<u>Knox County</u>	<u>100.00%</u>	<u>21,182</u>	<u>21,182</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>	<b>Total</b>		<b>\$</b>			<b>\$ 713,190</b>	<b>\$ *</b>	<b>713,190</b>	<b>14</b>

\* 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.

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.

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.

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.

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/06 Ending: 11/30/07

## 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	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											4
5	Conducted Business Transactions With The Nursing Home During The Reporting Period.											5
6											6	
7											7	
8											8	
9											9	
10											10	
11											11	
12											12	
13								TOTAL	\$		13	

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/06

Ending: 11/30/07

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, IL 61401  
 Phone Number ( 309) 345-3837  
 Fax Number ( 309) 343-7002

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits IMRF	Direct Cost		\$	\$		\$ 378,854	1
2	22	Employee Benefits FICA	Direct Cost					313,154	2
3	21	Bookkeeping & Accounting	Hours Worked	1,716	1716	21,182	1,716	21,182	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				\$ 21,182	\$		\$ 713,190	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/06

Ending: 11/30/07

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:

12/01/06

Ending: 11/30/07

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:

12/01/06

Ending: 11/30/07

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:

12/01/06

Ending: 11/30/07

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:

12/01/06

Ending: 11/30/07

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:

12/01/06

Ending: 11/30/07

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/06

Ending: 11/30/07

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:

12/01/06

Ending: 11/30/07

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:

12/01/06

Ending: 11/30/07

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				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Office Specialties, Inc.		X	Copier	\$243.41	09/2004	\$ 12,678	\$ 5,346	09/2009	0.0571	\$ 643	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	<b>Working Capital</b>											
6												6
7												7
8	See Supplemental Schedule											8
9	<b>TOTAL Facility Related</b>				\$243.41		\$ 12,678	\$ 5,346			\$ 643	9
	<b>B. Non-Facility Related*</b>											
10	Interest Income		X								(643)	10
11												11
12												12
13	See Supplemental Schedule											13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(643)	14
15	<b>TOTALS (line 9+line14)</b>						\$ 12,678	\$ 5,346			\$	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: 12/01/06 Ending: 11/30/07

**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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	<b>TOTAL Long-Term</b>																	
	<b>Working Capital</b>																	
8							\$	\$			\$	8						
9												9						
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Working Capital</b>																	
	<b>B. Non-Facility Related*</b>																	
15							\$	\$			\$	15						
16												16						
17												17						
18												18						
19												19						
20	<b>TOTAL Non-Facility Related</b>																	

\* 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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

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

**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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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:

12/01/06 Ending:

11/30/07

**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>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>1,481,040</b>		<b>\$ 156,600</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

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

# **0010561**

Report Period Beginning:

**12/01/06**

Ending:

**11/30/07**

**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	\$ 1,519,892	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	Various			1966	46,724		20	934	934	37,724	9
10	Various			1971	146,065		20			146,065	10
11	Various			1980	9,972		20			9,972	11
12	Various			1981	650		20			650	12
13	Various			1983	14,762		20			14,762	13
14	Various			1984	31,009		20			31,009	14
15	Various			1985	73,090		20			73,090	15
16	Various			1986	141,506		20			141,506	16
17	Various			1987	142,693		20			142,693	17
18	Various			1988	60,820		20	2,729	2,729	60,820	18
19	Various			1989	47,469		20	3,165	3,165	45,911	19
20	Various			1990	29,117		20	1,456	1,456	22,895	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	59,012	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	68,128	26
27	Various			1997	26,377		20			26,377	27
28	Various			1998	39,334		20	2,134	2,134	25,040	28
29	Various			1999	21,237		20	1,437	1,437	13,838	29
30	Various			2000	20,496		20	2,050	2,050	16,013	30
31	Various			2001	1,395		20	140	140	852	31
32	Various			2003	161,240		20	8,448	8,448	38,209	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:

12/01/06

Ending:

11/30/07

**XI. OWNERSHIP COSTS (continued)**

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	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	<a href="#">Related Building Company (Pages 12-BLDG &amp; 12A-BLDG)</a>								67
68	<a href="#">Related Party Allocations (Pages 12-REP &amp; 12A-REP)</a>								68
69	<a href="#">Financial Statement Depreciation</a>			225,605			(225,605)		69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,348,698	\$ 225,605		\$ 70,913	\$ (154,692)	\$ 2,813,384	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/06

Ending:

11/30/07

## 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		\$ 3,348,698	\$ 225,605		\$ 70,913	\$ (154,692)	\$ 2,813,384	1
2	Door	2004	1,352		20	68	68	203	2
3	New Condensing Unit	2004	8,933		20	447	447	1,340	3
4	Awning	2004	431		20	22	22	65	4
5	Renovation	2004	2,168		20	108	108	325	5
6	Air Handler - Fire Alarm	2004	2,483		20	124	124	372	6
7	Renovation	2004	290		20	14	14	43	7
8	Fire Doors	2004	4,230		20	212	212	635	8
9	Fire Door Installation	2004	4,500		20	225	225	675	9
10	Hvac	2004	5,900		20	295	295	885	10
11	Freight Elevator	2004	6,029		20	301	301	904	11
12	Fire Alarm System	2004	725		20	36	36	109	12
13	Architect - Remodel Rooms	2004	22,273		20	1,114	1,114	3,898	13
14	Hospice - Minor Renovation	2004	3,379		20	169	169	591	14
15	Bathroom Upgrade	2004	3,566		20	178	178	624	15
16	Condensing Unit	2004	9,182		20	918	918	3,213	16
17	Fire Doors	2004	11,238		20	1,124	1,124	3,934	17
18	Fire Alarm	2004	1,516		20	76	76	265	18
19	Call Light Cords	2004	2,163		20	108	108	378	19
20	Door Locks	2004	2,864		20	143	143	573	20
21	Resurface Parking Lot	2004	18,167		20	908	908	2,725	21
22	Architect	2004	3,224		20	161	161	484	22
23	Steam Distributing Coil	2004	1,715		20	86	86	257	23
24	Garbage Disposer	2005	1,994		20	100	100	299	24
25	Phone System	2005	2,177		20	109	109	327	25
26	Ejector Pump	2005	6,240		20	312	312	936	26
27	Smoke Dampers	2005	590		20	30	30	89	27
28	Elevator Upgrade	2005	32,880		20	1,644	1,644	4,932	28
29	Architect	2005	480		20	24	24	72	29
30	Wallcovering	2005	435		20	22	22	65	30
31	Wallcovering	2005	1,935		20	97	97	290	31
32	Flush Valve Converter	2005	636		20	32	32	95	32
33	Gauge Assembly For Boiler	2005	830		20	41	41	124	33
34	TOTAL (lines 1 thru 33)		\$ 3,513,222	\$ 225,605		\$ 80,160	\$ (145,445)	\$ 2,843,112	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/06

Ending:

11/30/07

## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,513,222	\$ 225,605		\$ 80,160	\$ (145,445)	\$ 2,843,112	1
2	Verticle Mt Emergenchshower And Other Inv	2005	1,456		20	73	73	218	2
3	Wall Covering W 2	2005	311		20	16	16	47	3
4	Drapery	2005	3,129		20	156	156	469	4
5	Faucets	2005	3,915		20	196	196	587	5
6	Cement Fire Lane	2005	300		20	15	15	45	6
7	Signage	2005	1,634		20	82	82	245	7
8	Water Chiller	2005	549		20	27	27	82	8
9	Remodeling / Redecorating	2005	170,256		20	8,513	8,513	25,538	9
10	Cooling Tower	2005	32,196		20	1,610	1,610	4,829	10
11	Remodeling / Redecorating	2005	4,688		20	234	234	703	11
12	Smoke Detector	2005	328		20	16	16	49	12
13	Faucets W-2	2005	637		20	32	32	96	13
14	Boiler Repair	2005	1,244		20	62	62	187	14
15	Architect	2005	400		20	20	20	60	15
16	Draperies Wing 2	2005	3,095		20	155	155	464	16
17	Chiller	2005	3,202		20	160	160	480	17
18	Cabinets For Main Dining Room	2005	637		20	32	32	95	18
19	Chiller Work	2005	622		20	31	31	93	19
20	Drapes & Hardware W-2	2005	1,277		20	64	64	192	20
21	Door Alarm	2005	203		20	10	10	30	21
22	Door Closers	2005	311		20	16	16	47	22
23	Chiller Work	2005	18,625		20	931	931	2,794	23
24	2 Ea Handicap Door Openers	2005	3,507		20	175	175	526	24
25	Architect	2005	960		20	48	48	144	25
26	2 Cabinets	2005	2,417		20	121	121	362	26
27	Set 4 Laminate Panels	2005	1,024		20	51	51	154	27
28	Remove And Replace Concrete	2005	600		20	30	30	90	28
29	Drapery Rods W-2	2005	344		20	17	17	52	29
30	Drapery Rods W-2	2005	324		20	16	16	49	30
31	Wiring For Outside Lights	2005	1,027		20	51	51	154	31
32	Plan Review	2005	6,000		20	300	300	900	32
33	Architect	2005	800		20	40	40	120	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,779,239	\$ 225,605		\$ 93,461	\$ (132,144)	\$ 2,883,014	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/06

Ending:

11/30/07

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,779,239	\$ 225,605		\$ 93,461	\$ (132,144)	\$ 2,883,014	1
2	Oxygen Room Door	2005	349		20	17	17	52	2
3	Locks	2005	728		20	36	36	73	3
4	Emergency Electric System - Panel	2005	1,860		20	93	93	186	4
5	Emergency Electric System - Transfer Switch	2005	4,425		20	221	221	443	5
6	Oxygen Room Mechanical Exhaust	2005	4,675		20	234	234	468	6
7	Door Locks	2006	1,400		20	70	70	140	7
8	Air Handler	2006	685		20	34	34	69	8
9	Wall Trim	2006	4,082		20	204	204	408	9
10	Wallcovering	2006	4,411		20	221	221	441	10
11	Shower Tub	2006	15,074		20	754	754	1,507	11
12	Fire Alarm Tamper Switches	2006	615		20	31	31	61	12
13	Smoke Detectors	2006	3,210		20	161	161	321	13
14	Room Signs	2006	1,090		20	55	55	109	14
15	Shower Tub	2006	15,074		20	754	754	1,507	15
16	Fire Door Lock	2006	1,711		20	86	86	171	16
17	Wing 4 Wall Covering-Trim	2006	2,008		20	100	100	201	17
18	Sprinkers, Sprinkler Heads And Caulking	2006	896		20	45	45	90	18
19	New Fire Alarm Panel And Remote Annunciator	2006	4,850		20	243	243	485	19
20	Smoke Detectors	2006	3,210		20	161	161	321	20
21	Fire Dampers	2006	1,425		20	71	71	143	21
22	Fire Dampers	2006	4,400		20	220	220	440	22
23	Fire Doors	2006	3,441		20	172	172	344	23
24	Wall Covering Wing 4	2006	3,087		20	154	154	309	24
25	Boiler Repair	2006	2,379		20	119	119	238	25
26	Faucets	2006	1,625		20	81	81	163	26
27	Wallpaper	2006	1,104		20	55	55	110	27
28	Wallcovering	2006	1,598		20	80	80	160	28
29	Drapery	2006	3,153		20	158	158	315	29
30	Fire Door Hardware	2006	1,015		20	51	51	102	30
31	Drapery	2006	3,156		20	158	158	316	31
32	Door Keypad System	2006	523		20	26	26	52	32
33	Tub Room Doors - Combo Lock	2006	681		20	34	34	68	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,877,179	\$ 225,605		\$ 98,358	\$ (127,247)	\$ 2,892,826	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/06

Ending:

11/30/07

**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	<b>Totals from Page 12D, Carried Forward</b>		\$ 3,877,179	\$ 225,605		\$ 98,358	\$ (127,247)	\$ 2,892,826	1
2	Faucets	2006	1,044		20	52	52	104	2
3	Repair Wing #1 Wall	2006	3,600		20	180	180	360	3
4	Wall Covering	2006	2,764		20	138	138	276	4
5	Pa System	2006	1,057		20	53	53	106	5
6	Drapes Wing 3	2006	838		20	42	42	84	6
7	Main Pump	2006	1,758		20	88	88	176	7
8	Call Light Panels	2006	668		20	33	33	67	8
9	Restroom - Wing 1	2006	4,117		20	206	206	412	9
10	Smoke Dectectors	2006	3,210		20	161	161	321	10
11	Smoke Dectectors	2006	1,220		20	61	61	122	11
12	Sprinkler System	2006	35,439		20	1,772	1,772	3,544	12
13	Grab Bars, Faucets And Shower Heads Hand Rails	2006	1,080		20	54	54	108	13
14	Moulding	2006	4,941		20	247	247	494	14
15	Wall Paper Border Wing 3	2006	943		20	47	47	94	15
16	Remodel Wing 3 & 4	2006	526,901		20	26,345	26,345	52,690	16
17	Wall Covering Wing3	2006	738		20	37	37	74	17
18	Roofing	2006	4,623		20	231	231	462	18
19	Room Signs*	2006	1,633		20	82	82	163	19
20	Floor Expansion Joints	2006	975		20	49	49	98	20
21	Sprinkler System	2006	46,376		20	2,319	2,319	4,638	21
22	Drapes Wing 3	2006	5,821		20	291	291	582	22
23	A/C Unit	2006	600		20	30	30	60	23
24	Sprinkler System	2006	150,040		20	7,502	7,502	15,004	24
25	Tile 2 Room Wing 3	2006	755		20	38	38	75	25
26	Concrete Sidewalk Slabs Around Building	2006	2,700		20	135	135	270	26
27	Roof Top A/C Unit	2006	6,556		20	328	328	656	27
28	Faucets And Labor W-3	2006	2,142		20	107	107	214	28
29	Door Levers	2006	681		20	34	34	68	29
30	Architect Consult Lsc	2006	1,800		20	90	90	180	30
31	Sprinkler System	2006	17,019		20	851	851	1,702	31
32	Sprinkler System	2006	27,280		20	1,364	1,364	2,728	32
33	4 Doors Temporary Lsc Sprinkler	2006	2,056		20	103	103	206	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,738,552	\$ 225,605		\$ 141,426	\$ (84,179)	\$ 2,978,963	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Knox County Nursing Home

# 0010561

Report Period Beginning:

12/01/06

Ending:

11/30/07

**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	<b>Totals from Page 12E, Carried Forward</b>		\$ 4,738,552	\$ 225,605		\$ 141,426	\$ (84,179)	\$ 2,978,963	1
2	Temporary Fire Walls	2006	656		20	33	33	66	2
3	Remove Replace Concrete Slab	2006	1,200		20	60	60	120	3
4	Installed Smoke Dect In All 4 Day Rooms	2006	1,359		20	68	68	136	4
5	Sprinkler System	2006	27,280		20	1,364	1,364	2,728	5
6	Sprinkler System	2006	17,019		20	851	851	1,702	6
7	Doors Lsc	2006	2,030		20	102	102	203	7
8	Doors Lsc	2006	2,145		20	107	107	215	8
9	Door Closer	2006	2,108		20	105	105	210	9
10	Wall Covering	2006	2,480		20	124	124	248	10
11	Installation & Cost 3 Smoke Detectors	2007	1,381		20	59	59	59	11
12	Sprinkler System	2007	14,399		20	613	613	613	12
13	(4) Photoelectric Smoke Dectectors	2007	145		20	6	6	6	13
14	Architect Sprinkler System	2007	3,040		20	115	115	115	14
15	Sprinkler System	2007	12,966		20	490	490	490	15
16	Fire Alarm Panel Upgrade For Sprinkler System	2007	1,850		20	70	70	70	16
17	1-Water Heater	2007	17,797		20	605	605	605	17
18	Consulting Engineer A/C Unit	2007	3,360		20	114	114	114	18
19	Smoke Detectors Center Core	2007	1,070		20	36	36	36	19
20	Duct Smoke Detectors	2007	15,730		20	534	534	534	20
21	A/C Plan Review	2007	3,971		20	123	123	123	21
22	A/C Design	2007	11,520		20	303	303	303	22
23	Remove&Replace Side Walk And Gutter	2007	1,200		20	32	32	32	23
24	Labor And Materials For Hot Water Heater (Materials \$1559.30) R	2007	3,755		20	99	99	99	24
25	Consulting A/C System	2007	5,760		20	106	106	106	25
26	1 Door For New Employee Entrance Wing 1	2007	2,223		20	29	29	29	26
27	Asbestos Removal	2007	4,800		20	62	62	62	27
28	Consulting For A/C	2007	750		20	7	7	7	28
29	Partial Payment A/C Roof Top Unit	2007	60,720		20	549	549	549	29
30	Under Ground Main Sewer Line Repair	2007	2,586		20	13	13	13	30
31	Under Ground Main Sewer Line Repair	2007	1,333		20	7	7	7	31
32	Under Ground Main Sewer Line Repair	2007	1,963		20	10	10	10	32
33	Roof Top Unit Compressor And Coil	2007	4,841		20	25	25	25	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,971,989	\$ 225,605		\$ 148,247	\$ (77,358)	\$ 2,988,597	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:

12/01/06

Ending:

11/30/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12F, Carried Forward</b>		\$ 4,971,989	\$ 225,605		\$ 148,247	\$ (77,358)	\$ 2,988,597	1
2	Labor To Install Damper	2007	960		20	5	5	5	2
3	Labor To Install Wiring Harness	2007	106		20	1	1	1	3
4	Install 14 Smoke Detectors	2007	4,200		20	22	22	22	4
5	Install Add 14 Smoke Detectors	2007	4,200		20	22	22	22	5
6	Install Add 9 Smoke Detectors	2007	2,700		20	14	14	14	6
7	Partial Pay New A/C Replacement	2007	114,778		20	597	597	597	7
8	Additional Invoices From Main Sewer Line Work	2007	58		20	0	0	0	8
9	Additional Invoices From Main Sewer Line Work	2007	254		20	0	0	0	9
10	Purchase Of Water Softner	2007	10,650		20	4	4	4	10
11	Partial Pay Replace A/C System	2007	157,192		20	65	65	65	11
12	Roof Top Ac Repair	2007	3,092		20	57	57	57	12
13	Painting Of Center Core And Corridors	2007	4,800		20	62	62	62	13
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33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,274,979	\$ 225,605		\$ 149,096	\$ (76,509)	\$ 2,989,446	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:

**12/01/06**

Ending:

**11/30/07**

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12G, Carried Forward</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	1
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34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	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:

**12/01/06**

Ending:

**11/30/07**

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12H, Carried Forward</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	1
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34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	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:

12/01/06

Ending:

11/30/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12I, Carried Forward</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	1
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34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	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:

**12/01/06**

Ending:

**11/30/07**

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12J, Carried Forward</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	1
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34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	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:

**12/01/06**

Ending:

**11/30/07**

**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	<b>Totals from Page 12K, Carried Forward</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	1
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34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	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:

**12/01/06**

Ending:

**11/30/07**

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12L, Carried Forward</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	1
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34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	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:

**12/01/06**

Ending:

**11/30/07**

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12M, Carried Forward</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	1
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34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

# **0010561**

Report Period Beginning:

12/01/06

Ending:

11/30/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12N, Carried Forward</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	1
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34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	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:

12/01/06

Ending:

11/30/07

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12O, Carried Forward</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	1
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34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	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:

**12/01/06**

Ending:

**11/30/07**

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12P, Carried Forward</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ <b>5,274,979</b>	\$ <b>225,605</b>		\$ <b>149,096</b>	\$ <b>(76,509)</b>	\$ <b>2,989,446</b>	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:

12/01/06

Ending:

11/30/07

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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.

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

# **0010561**

Report Period Beginning:

12/01/06

Ending:

11/30/07

**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	<b>TOTAL (lines 4 thru 69)</b>		\$	\$	\$	\$	\$

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:

**12/01/06**

Ending:

**11/30/07**

**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
	<b>Improvement Type**</b>										
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.

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

# **0010561**

Report Period Beginning:

12/01/06

Ending:

11/30/07

**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								69
70	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	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: 12/01/06 Ending: 11/30/07

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	\$ 862,831	\$	\$ 86,262	\$ 86,262	10	\$ 519,455	71
72	Current Year Purchases	94,851		4,100	4,100	10	4,100	72
73	Fully Depreciated Assets	327,648				10	327,648	73
74								74
75	TOTALS	\$ 1,285,330	\$	\$ 90,362	\$ 90,362		\$ 851,203	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	26,390	78
79	Facility	VAN	2005	34,452		6,890	6,890	5	20,671	79
80	TOTALS			\$ 106,287	\$	\$ 15,687	\$ 15,687		\$ 74,912	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)	\$ 6,823,195	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 225,605	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 255,146	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,541	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,915,562	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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 6,140 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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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

Facility Name & ID Number Knox County Nursing Home# 0010561 Report Period Beginning:

12/01/06 Ending:

11/30/07

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 02	hrs	\$		\$	\$ 86,470		\$ 86,470	1
2	Licensed Speech and Language Development Therapist	39 - 02	hrs				3,889		3,889	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 02	hrs				68,419		68,419	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				100,535		100,535	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <a href="#">See Supplemental</a>						91,560		91,560	13
14	TOTAL			\$		\$	\$ 350,873		\$ 350,873	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: 12/01/06

Ending:

11/30/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 153,514	\$	1
2	Cash-Patient Deposits	19,397		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	865,292		3
4	Supply Inventory (priced at )	28,594		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): <a href="#">See Attached Schedule</a>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,066,797	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	6,595,580		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(4,001,126)		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): <a href="#">See Attached Schedule</a>	914,055		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,508,509	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,575,306	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 352,549	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,397		28
29	Short-Term Notes Payable	5,346		29
30	Accrued Salaries Payable	256,000		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 633,292	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 633,292	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,942,014	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,575,306	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,208,907</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Audit Adjustments to Revenue &amp; Expenses</b>	<b>206,561</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,415,468</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>526,546</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>526,546</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,942,014</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

# 0010561

Report Period Beginning: 12/01/06

Ending: 11/30/07

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,956,748	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,956,748	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	38,657	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 38,657	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	5,215	12
13	Barber and Beauty Care	5,409	13
14	Non-Patient Meals	17,249	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 27,873	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	664,397	24
25	Interest and Other Investment Income***	57,269	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 721,666	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	102,289	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 102,289	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,847,233	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,502,779	31
32	Health Care	3,099,716	32
33	General Administration	1,004,504	33
<b>B. Capital Expense</b>			
34	Ownership	232,388	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	374,710	35
36	Provider Participation Fee	106,590	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,320,687	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	526,546	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 526,546	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:

12/01/06

Ending:

11/30/07

**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	1,860	1,984	\$ 54,121	\$ 27.28	1
2	Assistant Director of Nursing	1,872	2,296	48,726	21.22	2
3	Registered Nurses	11,174	12,513	314,782	25.16	3
4	Licensed Practical Nurses	34,757	38,921	763,741	19.62	4
5	CNAs & Orderlies	101,797	111,732	1,568,026	14.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,682	2,080	35,486	17.06	9
10	Activity Assistants	3,924	4,394	57,052	12.98	10
11	Social Service Workers	7,110	7,241	105,007	14.50	11
12	Dietician					12
13	Food Service Supervisor	1,798	1,945	30,901	15.89	13
14	Head Cook	1,918	2,075	27,942	13.47	14
15	Cook Helpers/Assistants	23,894	25,853	278,021	10.75	15
16	Dishwashers					16
17	Maintenance Workers	5,165	5,773	120,207	20.82	17
18	Housekeepers	16,845	19,228	204,166	10.62	18
19	Laundry	7,149	8,399	68,591	8.17	19
20	Administrator	1,852	2,080	80,898	38.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,943	7,591	144,984	19.10	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>	2,773	2,911	27,532	9.46	33
34	<b>TOTAL (lines 1 - 33)</b>	<b>232,513</b>	<b>257,016</b>	<b>\$ 3,930,183 *</b>	<b>\$ 15.29</b>	<b>34</b>

\* 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	253	\$ 9,866	01-03	35
36	Medical Director	Monthly	9,500	09-03	36
37	Medical Records Consultant	22	1,123	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,200	10-03	39
40	Physical Therapy Consultant	71	3,539	10a-03	40
41	Occupational Therapy Consultant	17	791	10a-03	41
42	Respiratory Therapy Consultant	8	276	10a-03	42
43	Speech Therapy Consultant	34	2,050	10a-03	43
44	Activity Consultant	52	2,605	11-03	44
45	Social Service Consultant	16	150	12-03	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>473</b>	<b>\$ 35,100</b>		<b>49</b>

**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	129	4,890	10-03	51
52	Certified Nurse Assistants/Aides				52
53	<b>TOTAL (lines 50 - 52)</b>	<b>129</b>	<b>\$ 4,890</b>		<b>53</b>

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Knox County Nursing Home

Report Period Beginning: 12/01/06 Ending: 11/30/07

**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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. County Nursing Home Association \$1,605
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 154
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,637 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 106,590  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 21,563
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Carpentier Mitchell Goddard & Company LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not Complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT