

		FOR BHF USE				

LL1

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: 0024265

Facility Name: KNOX ESTATES

Address: PO BOX 706, ENGLE DRIVE STREATOR 61364
 Number City Zip Code

County: LASALLE

Telephone Number: (815) 673-5574 **Fax #** (815) 673-1714

HFS ID Number: 36-2558089-042

Date of Initial License for Current Owners: 10/05/80

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 (c) (3)</u>	<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: JEFFREY M. DEAN **Telephone Number:** (815) 673-5574

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/06 to 06/30/07 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) _____
	(Type or Print Name) <u>JEFFREY M. DEAN</u>	
	(Title) <u>EXECUTIVE DIRECTOR</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>D. KEVIN MASON</u> <u>OWNER</u>	
	(Firm Name & Address) <u>MASON & ASSOCIATES</u> <u>1001 SHOOTING PARK ROAD, SUITE 105B</u>	
	(Telephone) <u>(815) 223-8808</u> Fax # <u>(815) 220-3529</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

Facility Name & ID Number KNOX ESTATES

0024265 Report Period Beginning: 07/01/06 Ending: 06/30/07

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 _____

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,490</u>			<u>5,490</u>
14	TOTALS	<u>5,490</u>			<u>5,490</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.01%

D. How many bed-hold days during this year were paid by the Department? 117 (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 01/05/1980

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1980 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: EXEMPT Fiscal Year: 06/30

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

Facility Name & ID Number **KNOX ESTATES** # **0024265** Report Period Beginning: **07/01/06** Ending: **06/30/07**

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
	A. General Services										
1	Dietary	26,049	2,346	2,546	30,941		30,941		30,941		1
2	Food Purchase		39,958		39,958		39,958		39,958		2
3	Housekeeping	10,798	2,811		13,609		13,609		13,609		3
4	Laundry		4,730		4,730		4,730		4,730		4
5	Heat and Other Utilities			19,953	19,953		19,953	(1,958)	17,995		5
6	Maintenance	6,783	11,015		17,798		17,798		17,798		6
7	Other (specify):*										7
8	TOTAL General Services	43,630	60,860	22,499	126,989		126,989	(1,958)	125,031		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	224,316	5,993	2,640	232,949		232,949		232,949		10
10a	Therapy			1,137	1,137		1,137		1,137		10a
11	Activities		8,212	607	8,819		8,819		8,819		11
12	Social Services			1,421	1,421		1,421		1,421		12
13	CNA Training	3,687			3,687		3,687		3,687		13
14	Program Transportation		12,563		12,563		12,563		12,563		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	228,003	26,768	5,805	260,576		260,576		260,576		16
	C. General Administration										
17	Administrative	69,766			69,766		69,766	109,070	178,836		17
18	Directors Fees										18
19	Professional Services			1,500	1,500		1,500		1,500		19
20	Dues, Fees, Subscriptions & Promotions			230	230		230		230		20
21	Clerical & General Office Expenses		4,175		4,175		4,175		4,175		21
22	Employee Benefits & Payroll Taxes			95,482	95,482		95,482		95,482		22
23	Inservice Training & Education			127	127		127		127		23
24	Travel and Seminar			1,007	1,007		1,007		1,007		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,828	3,828		3,828		3,828		26
27	Other (specify):*										27
28	TOTAL General Administration	69,766	4,175	102,174	176,115		176,115	109,070	285,185		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	341,399	91,803	130,478	563,680		563,680	107,112	670,792		29

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

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

Facility Name & ID Number KNOX ESTATES #0024265 Report Period Beginning: 07/01/06 Ending: 06/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			13,544	13,544	13,544	(4,808)	8,736			30
31	Amortization of Pre-Op. & Org.										31
32	Interest										32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			13,544	13,544	13,544	(4,808)	8,736			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			40,632	40,632	40,632		40,632			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			40,632	40,632	40,632		40,632			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	341,399	91,803	184,654	617,856	617,856	102,304	720,160			45

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

Facility Name & ID Number KNOX ESTATES

0024265

Report Period Beginning: 07/01/06

Ending: 06/30/07

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				4
5	Telephone, TV & Radio in Resident Rooms	(1,958)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,808)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (6,766)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule Schedule VIII	109,070	17	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 109,070		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 102,304		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

KNOX ESTATES

ID# 0024265
Report Period Beginning: 07/01/06
Ending: 06/30/07

Sch. V Line
Reference

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
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number KNOX ESTATES

0024265

Report Period Beginning:

07/01/06

Ending:

06/30/07

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,958)	0	0	0	0	0	0	0	0	0	0	(1,958)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,958)	0	0	0	0	0	0	0	0	0	0	(1,958)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	109,070	0	0	0	0	0	0	0	0	0	0	109,070	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	109,070	0	0	0	0	0	0	0	0	0	0	109,070	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	107,112	0	0	0	0	0	0	0	0	0	0	107,112	29

STATE OF ILLINOIS

Facility Name & ID Number KNOX ESTATES

0024265

Report Period Beginning:

07/01/06 Ending:

Summary B

06/30/07

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(4,808)	0	0	0	0	0	0	0	0	0	0	(4,808)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,808)	0	(4,808)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	102,304	0	102,304	45									

Facility Name & ID Number KNOX ESTATES

0024265

Report Period Beginning:

07/01/06

Ending:

06/30/07

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
STREATOR UNLIMITED	100%					

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	
1	V		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

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

Facility Name & ID Number

KNOX ESTATES

#

0024265

Report Period Beginning:

07/01/06

Ending:

06/30/07

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number KNOX ESTATES

0024265 Report Period Beginning: 07/01/06

Ending: 06/30/07

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 STREATOR UNLIMITED
 Street Address 305 N. STERLING
 City / State / Zip Code STREATOR, IL 61364
 Phone Number (815) 673-5574
 Fax Number (815) 673-1714

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	17	ALLOWABLE ADMIN. COSTS	DIRECT BUDGETED COST	1,899,055	6	\$ 338,786	\$ 200,709	611,390	\$ 109,070	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					\$ 338,786	\$ 200,709		\$ 109,070	25

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

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

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

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

Facility Name & ID Number **KNOX ESTATES**

0024265 Report Period Beginning: **07/01/06**

Ending: **06/30/07**

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	8	
	2003	9	
	2004	10	
	2005	11	
	2006	12	
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

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 ESTATES COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0024265

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 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.

Facility Name & ID Number KNOX ESTATES

0024265 Report Period Beginning:

07/01/06 Ending:

06/30/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,004 B. General Construction Type: Exterior BRICK VENEER Frame WOOD 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).

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>RESIDENTIAL</u>	<u>211,540</u>	<u>1976</u>	<u>\$ 26,838</u>	<u>1</u>
2	<u>IDLE</u>	<u>229,115</u>		<u>6,232</u>	<u>2</u>
3	TOTALS	440,655		\$ 33,070	3

Facility Name & ID Number **KNOX ESTATES**

0024265

Report Period Beginning:

07/01/06

Ending:

06/30/07

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1980	1980	\$ 347,142	\$		\$	\$	\$ 347,142	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ASPHALT ROAD		1986		488		20			488	9
10	CONNES BROS.		1986		2,229		20			2,229	10
11	ELECTRICAL		1987		10,483		20			10,483	11
12	TILING		1987		828		20			828	12
13	ADDITION		1992		6,623		10			6,623	13
14	SOIL BORING & PERCOLATING TESTING		1994		1,252	83	15	83		1,117	14
15	SEWER TILE & LEACH FIELD REMOVAL & REPLACEMENT		1995		26,909	1,794	15	1,794		22,409	15
16	FLOORING		1996		1,083		10			1,083	16
17	FLOOR TILE & MOLDING		2001		2,110	106	20	106		614	17
18	ROOF		2001		30,600	1,530	20	1,530		8,741	18
19	FLOORING		2004		2,345	117	20	117		415	19
20	CARPETING		2005		4,265	213	20	213		329	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **KNOX ESTATES**

0024265

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	TOTAL (lines 4 thru 69)	\$	436,357	\$	3,843	\$	3,843	\$	402,501	70

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

Facility Name & ID Number KNOX ESTATES # 0024265 Report Period Beginning: 07/01/06 Ending: 06/30/07

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	\$ 33,672	\$ 4,317	\$ 4,317	\$		\$ 26,884	71
72	Current Year Purchases	6,353	576	576			576	72
73	Fully Depreciated Assets	42,216					42,216	73
74								74
75	TOTALS	\$ 82,241	\$ 4,893	\$ 4,893	\$		\$ 69,676	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 551,668	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,736	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 8,736	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 472,177	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	1990 VAN	\$ 8,371	\$	\$ 8,371	86
87	1994 DODGE VAN	14,802		14,802	87
88	1996 DODGE RAM VAN	29,580		29,580	88
89	2005 CHEVY VENTURE	21,484	4,297	10,742	89
90	1996 AMBULANCE VAN - 2007	5,108	511	511	90
91	TOTALS	\$ 79,345	\$ 4,808	\$ 64,006	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number KNOX ESTATES

0024265

Report Period Beginning: 07/01/06

Ending: 06/30/07

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

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

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: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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)	457	730		1,187
4	Clinical Wages (b)		1,312		1,312
5	In-House Trainer Wages (c)	436	752		1,188
6	Transportation				
7	Contractual Payments			19	19
8	CNA Competency Tests				
9	TOTALS	\$ 893	\$ 2,794	\$ 19	\$ 3,706
10	SUM OF line 9, col. 1 and 2 (e)	\$ 3,687			

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
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	4

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **KNOX ESTATES**# **0024265**Report Period Beginning: **07/01/06**

Ending:

06/30/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **06/30/07**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 171,761	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>NONE</u>)	127,605	309,823	3
4	Supply Inventory (priced at <u>COST</u>)		21,753	4
5	Short-Term Investments			5
6	Prepaid Insurance		29,615	6
7	Other Prepaid Expenses		9,479	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>BOND RESERVE ACCOUNTS</u>		265,864	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 127,605	\$ 808,295	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		60,300	12
13	Land	33,070	89,020	13
14	Buildings, at Historical Cost	436,357	1,703,228	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	161,586	1,031,761	16
17	Accumulated Depreciation (book methods)	(536,176)	(1,844,108)	17
18	Deferred Charges		37,877	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 94,837	\$ 1,078,078	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 222,442	\$ 1,886,373	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 7,391	\$ 22,962	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,021	111,900	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		22,428	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>LINE OF CREDIT</u>		26,750	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 43,412	\$ 184,040	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		710,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 710,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 43,412	\$ 894,040	46
47	TOTAL EQUITY(page 18, line 24)	\$ 179,030	\$ 992,333	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 222,442	\$ 1,886,373	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 170,142	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 170,142	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	68,871	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Allocated Indirect Costs (Sch. VIII)	(109,070)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (40,199)	17
B. Transfers (Itemize):			
18	STREATOR UNLIMITED, INC	49,087	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 49,087	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 179,030	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **KNOX ESTATES**# **0024265**Report Period Beginning: **07/01/06**Ending: **06/30/07****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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 674,528	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 674,528	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,718	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	276	15
16	Rental of Facility Space	1,014	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,008	23
D. Non-Operating Revenue			
24	Contributions	8,814	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,814	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING & RECYCLING	358	28
28a	GAIN ON SALE OF ASSETS	19	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 377	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 686,727	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	126,989	31
32	Health Care	260,576	32
33	General Administration	176,115	33
B. Capital Expense			
34	Ownership	13,544	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	40,632	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 617,856	40
41	Income before Income Taxes (line 30 minus line 40)**	68,871	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 68,871	43

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

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

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

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

Facility Name & ID Number **KNOX ESTATES**

0024265

Report Period Beginning:

07/01/06

Ending:

06/30/07

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
2	Assistant Director of Nursing				2
3	Registered Nurses	764	820	15,904	19.40
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,945	2,154	19,654	9.12
15	Cook Helpers/Assistants	890	890	6,395	7.19
16	Dishwashers				16
17	Maintenance Workers	321	392	6,783	17.30
18	Housekeepers	1,469	1,567	10,798	6.89
19	Laundry				19
20	Administrator	1,294	1,456	28,460	19.55
21	Assistant Administrator	1,355	1,537	24,067	15.66
22	Other Administrative	882	1,024	17,239	16.83
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,104	1,269	24,592	19.38
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	16,778	18,708	178,060	9.52
31	Medical Records	677	743	9,447	12.71
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	27,479	30,560	\$ 341,399 *	\$ 11.17

* 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	31	\$ 2,546	35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	8	400	39
40	Physical Therapy Consultant	1	35	40
41	Occupational Therapy Consultant	1	35	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	2	131	43
44	Activity Consultant	9	596	44
45	Social Service Consultant	21	1,421	45
46	Other(specify) <u>PSYCHOLOGIST</u>	8	1,100	46
47	<u>DENTAL/EYE DOCTOR</u>		1,494	47
48	<u>PROSTHETICS/PREVENTATIVE MED</u>		582	48
49	TOTAL (lines 35 - 48)	81	\$ 8,340	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

Facility Name & ID Number **KNOX ESTATES**

0024265

Report Period Beginning: **07/01/06**

Ending: **06/30/07**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
JULIE CARSTENS	DIR OF RES. SERVICES		\$ 28,460	Workers' Compensation Insurance	\$ 9,170	IDPH License Fee	\$		
LISA BENNER	ASST DIR OF RES. SERVICES		24,067	Unemployment Compensation Insurance		Advertising: Employee Recruitment			
TERI BRADLEY	REP PAYEE		17,239	FICA Taxes	25,622	Health Care Worker Background Check			
				Employee Health Insurance	54,870	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		INHAA MEMBERSHIP	100		
				RETIREMENT CONTRIBUTION	5,530	COMM. RESIDENTIAL PROVIDER DUES	27		
				EMPLOYMENT ADVERTISEMENT	290	ACTIVITY DIRECTOR ASSN. DUES	20		
						SUBSCRIPTIONS	83		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 69,766			Less: Public Relations Expense	()		
(List each licensed administrator separately.)						Non-allowable advertising	()		
						Yellow page advertising	()		
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		\$ 230	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 95,482		
			\$						
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description			Line #	Amount	
C. Professional Services							Description		Amount
Vendor/Payee	Type		Amount						
MASON & ASSOCIATES	ACCOUNTING FEES		\$ 1,500				Out-of-State Travel		\$
							In-State Travel		214
							Seminar Expense		793
							Entertainment Expense		()
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 1,500	TOTAL			\$	TOTAL	1,007
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

KNOX ESTATES/STREATOR UNLIMITED, INC.

#0024265

PAGE 21 ATTACHMENT

JULY 1, 2006 - JUNE 30, 2007

PAGE 21, SECTION XIX, PART G							
DATE	INDIVIDUAL	TITLE	SEMINAR TITLE	LOCATION	SPONSOR	COST	DESCRIPTION
9/18/2006	Michelle Jakupcak	DSP II	First Aid	Streator, IL	Red Cross	\$ 9.00	Seminar Cost
9/18/2006	Anthony Houston	DSP II	First Aid	Streator, IL	Red Cross	20.00	Seminar Cost
9/18/2006	Teri Bradley	Consumer Ben. Advocate	First Aid	Streator, IL	Red Cross	7.20	Seminar Cost
10/18/2006	Julie Carstens	Dir of Residential Svcs.	Eggs & Issues	Streator, IL	SACCI	7.00	Seminar Cost
12/4/2006	Dolores Byars	DSP I	First Aid	Streator, IL	Red Cross	5.00	Seminar Cost
12/4/2006	Michelle Williams	DSP II	First Aid	Streator, IL	Red Cross	5.00	Seminar Cost
2/1/2007	Julie Carstens	Dir of Residential Svcs.	Leadership Conference	Lisle, IL	ICEARC	40.99	Travel
2/1/2007	Julie Carstens	Dir of Residential Svcs.	Medicaid Transformation	Lisle, IL	ICEARC	154.00	Seminar Cost
2/8/2007	Julie Carstens	Dir of Residential Svcs.	INHAA Training	East Peoria, IL	INHAA	95.00	Seminar Cost
3/13/2007	Lisa Renner	Asst Dir of Res Services	Social Security/Public Aid	McHenry, IL	Pioneer Ctr	19.60	Seminar Cost
3/13/2007	Teri Bradley	Consumer Ben. Advocate	Social Security/Public Aid	McHenry, IL	Pioneer Ctr	18.00	Seminar Cost
3/13/2007	Lisa Renner	Asst Dir of Res Services	Social Security/Public Aid	McHenry, IL	Pioneer Ctr	5.41	Travel
3/13/2007	Teri Bradley	Consumer Ben. Advocate	Social Security/Public Aid	McHenry, IL	Pioneer Ctr	60.79	Travel
3/19/2007	Jackie Estes	DSP II	First Aid	Streator, IL	Red Cross	5.00	Seminar Cost
4/3/2007	Lisa Renner	Asst Dir of Res Services	Benefits & Employment	Ottawa, IL	M. Walling	33.08	Seminar Cost
4/3/2007	Teri Bradley	Consumer Ben. Advocate	Benefits & Employment	Ottawa, IL	M. Walling	36.02	Seminar Cost
4/3/2007	Teri Bradley	Consumer Ben. Advocate	Benefits & Employment	Ottawa, IL	M. Walling	13.21	Travel
4/3/2007	Lisa Renner	Asst Dir of Res Services	Benefits & Employment	Ottawa, IL	M. Walling	7.10	Travel
4/11/2007	Lisa Renner	Asst Dir of Res Services	Food Sanitation	Oglesby, IL	IL Health Department	134.45	Seminar Cost
5/2/2007	Teri Bradley	Consumer Ben. Advocate	PASS Training	Bloomington, IL	DHS	33.65	Travel
5/11/2007	John Neiggemann	Food Serive Director	Food Sanitation	Oglesby, IL	IL Health Department	70.75	Seminar Cost
5/22/2007	Julie Carstens	Dir of Residential Svcs.	Tools to Become Self Advocate		ARC of Illinois	8.00	Seminar Cost
5/22/2007	Julie Carstens	Dir of Residential Svcs.	Tools to Become Self Advocate		ARC of Illinois	52.96	Travel
6/5/2007	Julie Carstens	Dir of Residential Svcs.	Building a Nursing Home Safety Cul.		INHAA	95.00	Seminar Cost
6/13/2007	Kayla Williams	Cook	Food Sanitation	Oglesby, IL	IL Health Department	70.75	Seminar Cost
						\$ 1,006.96	

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (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? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,911 Line 4
- (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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 40,632
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? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
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? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 17,617
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: MASON & ASSOCIATES The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (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.