

Facility Name & ID Number Knox County Nursing Home

0010561 Report Period Beginning: 12/01/07 Ending: 11/30/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	154	Skilled (SNF)	154	56,364	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	154	TOTALS	154	56,364	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,360		5,555	8,915	8
9	SNF/PED					9
10	ICF	23,509	8,903	4	32,416	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,869	8,903	5,559	41,331	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.33%

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 2,415

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: 11/30/08 Fiscal Year: 11/30/08

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

Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/07 Ending: 11/30/08

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	376,792	26,260	11,285	414,337		414,337	414,337			1
2	Food Purchase		233,396		233,396		233,396	233,396			2
3	Housekeeping	191,176	22,992		214,168		214,168	214,168			3
4	Laundry	70,136	10,898	71,073	152,107		152,107	152,107			4
5	Heat and Other Utilities			251,888	251,888		251,888	(3,242)	248,646		5
6	Maintenance	134,135	2,059	104,148	240,342		240,342	240,342			6
7	Other (specify):*										7
8	TOTAL General Services	772,239	295,605	438,394	1,506,238		1,506,238	(3,242)	1,502,996		8
	B. Health Care and Programs										
9	Medical Director			9,750	9,750		9,750	9,750			9
10	Nursing and Medical Records	2,818,621	144,248	32,138	2,995,007		2,995,007	2,995,007			10
10a	Therapy			69	69		69	69			10a
11	Activities	84,720		1,180	85,900		85,900	85,900			11
12	Social Services	97,768	5,407	1,180	104,355		104,355	104,355			12
13	CNA Training										13
14	Program Transportation	33,238		10,493	43,731		43,731	43,731			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,034,347	149,655	54,810	3,238,812		3,238,812	3,238,812			16
	C. General Administration										
17	Administrative	83,197			83,197		83,197	83,197			17
18	Directors Fees										18
19	Professional Services			22,327	22,327		22,327	(1,545)	20,782		19
20	Dues, Fees, Subscriptions & Promotions			10,902	10,902		10,902	10,902			20
21	Clerical & General Office Expenses	149,759	13,961	73,898	237,618		237,618	1,069	238,687		21
22	Employee Benefits & Payroll Taxes			532,523	532,523		532,523	623,215	1,155,738		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,332	8,332		8,332	(2,017)	6,315		24
25	Other Admin. Staff Transportation			846	846		846	846			25
26	Insurance-Prop.Liab.Malpractice			19,290	19,290		19,290	19,290			26
27	Other (specify):*										27
28	TOTAL General Administration	232,956	13,961	668,118	915,035		915,035	620,722	1,535,757		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,039,542	459,221	1,161,322	5,660,085		5,660,085	617,480	6,277,565		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Knox County Nursing Home #0010561 Report Period Beginning: 12/01/07 Ending: 11/30/08

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			236,351	236,351	236,351	30,293	266,644			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			3,796	3,796	3,796		3,796			35
36	Other (specify):*										36
37	TOTAL Ownership			240,790	240,790	240,790	29,650	270,440			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		295,473		295,473	295,473		295,473			39
40	Barber and Beauty Shops	8,567		525	9,092	9,092		9,092			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			84,546	84,546	84,546		84,546			42
43	Other (specify):*			148,146	148,146	148,146	(148,146)				43
44	TOTAL Special Cost Centers	8,567	295,473	233,217	537,257	537,257	(148,146)	389,111			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,048,109	754,694	1,635,329	6,438,132	6,438,132	498,984	6,937,116			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: 12/01/07

Ending: 11/30/08

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	(3,242)	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	30,293	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	(36,157)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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	(151,776)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (161,525)		\$	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)	660,509		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 660,509		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 498,984		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Knox County Nursing Home

ID# 0010561

Report Period Beginning: 12/01/07

Ending: 11/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Farm:	\$		1
2	Contingencies	(17,341)	43	2
3	Current Taxes	(676)	43	3
4	Meals on Wheels	(83,005)	43	4
5	Bank Charges	(68)	21	5
6	Marketing	(12,319)	43	6
7	Walking Trail / Garden Grant Expense	(34,805)	43	7
8	Prior Period Legal Fees	(1,545)	19	8
9	Non-Allowable Seminar Expense (Prepaid for 2009)	(780)	24	9
10	Out of State Seminar	(1,237)	24	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	(151,776)		49

Knox County Nursing Home

ID# 0010561

Report Period Beginning: 12/01/07

Ending: 11/30/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/07

Ending:

11/30/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,242)											(3,242)	5
6	Maintenance													6
7	Other (specify):*													7
8	TOTAL General Services	(3,242)											(3,242)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(1,545)											(1,545)	19
20	Fees, Subscriptions & Promotions													20
21	Clerical & General Office Expenses	(36,225)	37,294										1,069	21
22	Employee Benefits & Payroll Taxes		623,215										623,215	22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,017)											(2,017)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(39,787)	660,509										620,722	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(43,029)	660,509										617,480	29

STATE OF ILLINOIS

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/07

Ending:

Summary B

11/30/08

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	30,293											30,293	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(643)											(643)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	29,650											29,650	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(148,146)											(148,146)	43
44	TOTAL Special Cost Centers	(148,146)											(148,146)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(161,525)	660,509										498,984	45

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/07

Ending:

11/30/08

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>Knox County</u>	<u>100.00%</u>	\$ <u>319,238</u>	\$ <u>319,238</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>303,977</u>	<u>303,977</u>	<u>2</u>
<u>3</u>	<u>V</u>	<u>21</u> <u>Bookkeeping & Account</u>		<u>Knox County</u>	<u>100.00%</u>	<u>37,294</u>	<u>37,294</u>	<u>3</u>
<u>4</u>	<u>V</u>							<u>4</u>
<u>5</u>	<u>V</u>							<u>5</u>
<u>6</u>	<u>V</u>							<u>6</u>
<u>7</u>	<u>V</u>							<u>7</u>
<u>8</u>	<u>V</u>							<u>8</u>
<u>9</u>	<u>V</u>							<u>9</u>
<u>10</u>	<u>V</u>							<u>10</u>
<u>11</u>	<u>V</u>							<u>11</u>
<u>12</u>	<u>V</u>							<u>12</u>
<u>13</u>	<u>V</u>							<u>13</u>
<u>14</u>	Total		\$			\$ <u>660,509</u>	\$ * <u>660,509</u>	<u>14</u>

* 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.

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.

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: 12/01/07 Ending: 11/30/08

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 Holds Committee Meetings Relating Only To The Nursing Home.								\$		1
2	Per Diems and Mileage Are Paid Separately 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	County Board Members					0.50	1.25%	Gas & Per Diem	2,666	25-03	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,666		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: 12/01/07

Ending: 11/30/08

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
 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	Diret Cost			\$		\$ 319,238	1
2	22	Employee Ben. - Payroll Taxes	Diret Cost					303,977	2
3	21	Bookkeeping & Account	Hours Worked	2,080	2080	37,294	2,080	37,294	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					\$ 37,294		\$ 660,509	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning: 12/01/07

Ending: 11/30/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning: 12/01/07

Ending: 11/30/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/07

Ending: 11/30/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning: 12/01/07

Ending: 11/30/08

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

12/01/07

Ending: 11/30/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning: 12/01/07

Ending: 11/30/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561 Report Period Beginning: 12/01/07

Ending: 11/30/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning: 12/01/07

Ending: 11/30/08

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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: 12/01/07

Ending: 11/30/08

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Office Supplies, Inc.	Copier	X		\$243.41	09/2004	\$ 12,678	\$ 2,794			\$ 643	1
2												2
3												3
4												4
5	See Supplemental Schedule											
	Working Capital											
6												6
7												7
8	See Supplemental Schedule											
9	TOTAL Facility Related				\$243.41		\$ 12,678	\$ 2,794			\$ 643	9
	B. Non-Facility Related*											
10	Interest Income										(643)	10
11												11
12												12
13	See Supplemental Schedule											
14	TOTAL Non-Facility Related						\$	\$			(643)	14
15	TOTALS (line 9+line14)						\$ 12,678	\$ 2,794			\$	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: 12/01/07 Ending: 11/30/08

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$				\$						
2																		
3																		
4																		
5																		
6																		
7	TOTAL Long-Term																	
	Working Capital																	
8							\$	\$				\$						
9																		
10																		
11																		
12																		
13																		
14	TOTAL Working Capital																	
	B. Non-Facility Related*																	
15							\$	\$				\$						
16																		
17																		
18																		
19																		
20	TOTAL Non-Facility Related																	

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2008 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:				
2003	_____	8		
2004	_____	9		
2005	_____	10		
2006	_____	11		
2007	_____	12		
<u>Facility is exempt from paying real estate taxes</u>				
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Knox County Nursing Home COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0010561

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Knox County Nursing Home

0010561 Report Period Beginning:

12/01/07 Ending:

11/30/08

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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning:

12/01/07

Ending:

11/30/08

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	\$ 1,556,736	4
5											5
6											6
7											7
8											8
Improvement Type**											
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	Various			2004	116,328		20	6,837	6,837	22,498	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:

12/01/07

Ending:

11/30/08

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
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52									52
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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	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)								68
69	Financial Statement Depreciation			236,351			(236,351)		69
70	TOTAL (lines 4 thru 69)		\$ 3,465,026	\$ 236,351		\$ 77,750	\$ (158,601)	\$ 2,872,726	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:

12/01/07

Ending:

11/30/08

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		\$ 3,465,026	\$ 236,351		\$ 77,750	\$ (158,601)	\$ 2,872,726	1
2	Garbage Disposer	2005	1,994		20	100	100	299	2
3	Phone System	2005	2,177		20	109	109	327	3
4	Ejector Pump	2005	6,240		20	312	312	936	4
5	Smoke Dampers	2005	590		20	30	30	89	5
6	Elevator Upgrade	2005	32,880		20	1,644	1,644	4,932	6
7	Architect	2005	480		20	24	24	72	7
8	Wallcovering	2005	435		20	22	22	65	8
9	Wallcovering	2005	1,935		20	97	97	290	9
10	Flush Valve Converter	2005	636		20	32	32	95	10
11	Gauge Assembly For Boiler	2005	830		20	41	41	124	11
12	Verticle Mt Emergenchshower And Other Inv	2005	1,456		20	73	73	218	12
13	Wall Covering W 2	2005	311		20	16	16	47	13
14	Drapery	2005	3,129		20	156	156	469	14
15	Faucets	2005	3,915		20	196	196	587	15
16	Cement Fire Lane	2005	300		20	15	15	45	16
17	Signage	2005	1,634		20	82	82	245	17
18	Water Chiller	2005	549		20	27	27	82	18
19	Remodeling / Redecorating	2005	170,256		20	8,513	8,513	25,538	19
20	Cooling Tower	2005	32,196		20	1,610	1,610	4,829	20
21	Remodeling / Redecorating	2005	4,688		20	234	234	703	21
22	Smoke Defecter	2005	328		20	16	16	49	22
23	Faucets W-2	2005	637		20	32	32	96	23
24	Boiler Repair	2005	1,244		20	62	62	187	24
25	Architect	2005	400		20	20	20	60	25
26	Draperies Wing 2	2005	3,095		20	155	155	464	26
27	Chiller	2005	3,202		20	160	160	480	27
28	Cabinets For Main Dining Room	2005	637		20	32	32	95	28
29	Chiller Work	2005	622		20	31	31	93	29
30	Drapes & Hardware W-2	2005	1,277		20	64	64	192	30
31	Door Alarm	2005	203		20	10	10	30	31
32	Door Closers	2005	311		20	16	16	47	32
33	Chiller Work	2005	18,625		20	931	931	2,794	33
34	TOTAL (lines 1 thru 33)		\$ 3,762,236	\$ 236,351		\$ 92,611	\$ (143,740)	\$ 2,917,308	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:

12/01/07

Ending:

11/30/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,762,236	\$ 236,351		\$ 92,611	\$ (143,740)	\$ 2,917,308	1
2	2 Ea Handicap Door Openers	2005	3,507		20	175	175	526	2
3	Architect	2005	960		20	48	48	144	3
4	2 Cabinets	2005	2,417		20	121	121	362	4
5	Set 4 Laminate Panels	2005	1,024		20	51	51	154	5
6	Remove And Replace Concrete	2005	600		20	30	30	90	6
7	Drapery Rods W-2	2005	344		20	17	17	52	7
8	Drapery Rods W-2	2005	324		20	16	16	49	8
9	Wiring For Outside Lights	2005	1,027		20	51	51	154	9
10	Plan Review	2005	6,000		20	300	300	900	10
11	Architect	2005	800		20	40	40	120	11
12	Oxygen Room Door	2005	349		20	17	17	52	12
13	Locks	2005	728		20	36	36	73	13
14	Emergency Electric System - Panel	2005	1,860		20	93	93	186	14
15	Emergency Electric System - Transfer Switch	2005	4,425		20	221	221	443	15
16	Oxygen Room Mechanical Exhaust	2005	4,675		20	234	234	468	16
17	Door Locks	2006	1,400		20	70	70	140	17
18	Air Handler	2006	685		20	34	34	69	18
19	Wall Trim	2006	4,082		20	204	204	408	19
20	Wallcovering	2006	4,411		20	221	221	441	20
21	Shower Tub	2006	15,074		20	754	754	1,507	21
22	Fire Alarm Tamper Switches	2006	615		20	31	31	61	22
23	Smoke Detectors	2006	3,210		20	161	161	321	23
24	Room Signs	2006	1,090		20	55	55	109	24
25	Shower Tub	2006	15,074		20	754	754	1,507	25
26	Fire Door Lock	2006	1,711		20	86	86	171	26
27	Wing 4 Wall Covering-Trim	2006	2,008		20	100	100	201	27
28	Sprinkers, Sprinkler Heads And Caulking	2006	896		20	45	45	90	28
29	New Fire Alarm Panel And Remote Annunciator	2006	4,850		20	243	243	485	29
30	Smoke Detectors	2006	3,210		20	161	161	321	30
31	Fire Dampers	2006	1,425		20	71	71	143	31
32	Fire Dampers	2006	4,400		20	220	220	440	32
33	Fire Doors	2006	3,441		20	172	172	344	33
34	TOTAL (lines 1 thru 33)		\$ 3,858,858	\$ 236,351		\$ 97,442	\$ (138,909)	\$ 2,927,838	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:

12/01/07

Ending:

11/30/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,858,858	\$ 236,351		\$ 97,442	\$ (138,909)	\$ 2,927,838	1
2	Wall Covering Wing 4	2006	3,087		20	154	154	309	2
3	Boiler Repair	2006	2,379		20	119	119	238	3
4	Faucets	2006	1,625		20	81	81	163	4
5	Wallpaper	2006	1,104		20	55	55	110	5
6	Wallcovering	2006	1,598		20	80	80	160	6
7	Draperly	2006	3,153		20	158	158	315	7
8	Fire Door Hardware	2006	1,015		20	51	51	102	8
9	Draperly	2006	3,156		20	158	158	316	9
10	Door Keypad System	2006	523		20	26	26	52	10
11	Tub Room Doors - Combo Lock	2006	681		20	34	34	68	11
12	Faucets	2006	1,044		20	52	52	104	12
13	Repair Wing #1 Wall	2006	3,600		20	180	180	360	13
14	Wall Covering	2006	2,764		20	138	138	276	14
15	Pa System	2006	1,057		20	53	53	106	15
16	Drapes Wing 3	2006	838		20	42	42	84	16
17	Main Pump	2006	1,758		20	88	88	176	17
18	Call Light Panels	2006	668		20	33	33	67	18
19	Restroom - Wing 1	2006	4,117		20	206	206	412	19
20	Smoke Dectectors	2006	3,210		20	161	161	321	20
21	Smoke Dectectors	2006	1,220		20	61	61	122	21
22	Sprinkler System	2006	35,439		20	1,772	1,772	3,544	22
23	Grab Bars, Faucets And Shower Heads Hand Rails	2006	1,080		20	54	54	108	23
24	Moulding	2006	4,941		20	247	247	494	24
25	Wall Paper Border Wing 3	2006	943		20	47	47	94	25
26	Remodel Wing 3 & 4	2006	526,901		20	26,345	26,345	52,690	26
27	Wall Covering Wing3	2006	738		20	37	37	74	27
28	Roofing	2006	4,623		20	231	231	462	28
29	Room Signs*	2006	1,633		20	82	82	163	29
30	Floor Expansion Joints	2006	975		20	49	49	98	30
31	Sprinkler System	2006	46,376		20	2,319	2,319	4,638	31
32	Drapes Wing 3	2006	5,821		20	291	291	582	32
33	A/C Unit	2006	600		20	30	30	60	33
34	TOTAL (lines 1 thru 33)		\$ 4,527,524	\$ 236,351		\$ 130,875	\$ (105,476)	\$ 2,994,704	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:

12/01/07

Ending:

11/30/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,527,524	\$ 236,351		\$ 130,875	\$ (105,476)	\$ 2,994,704	1
2	Sprinkler System	2006	150,040		20	7,502	7,502	15,004	2
3	Tile 2 Room Wing 3	2006	755		20	38	38	75	3
4	Concrete Sidewalk Slabs Around Building	2006	2,700		20	135	135	270	4
5	Roof Top A/C Unit	2006	6,556		20	328	328	656	5
6	Faucets And Labor W-3	2006	2,142		20	107	107	214	6
7	Door Levers	2006	681		20	34	34	68	7
8	Architect Consult Lsc	2006	1,800		20	90	90	180	8
9	Sprinkler System	2006	17,019		20	851	851	1,702	9
10	Sprinkler System	2006	27,280		20	1,364	1,364	2,728	10
11	4 Doors Temporary Lsc Sprinkler	2006	2,056		20	103	103	206	11
12	Temporary Fire Walls	2006	656		20	33	33	66	12
13	Remove Replace Concrete Slab	2006	1,200		20	60	60	120	13
14	Installed Smoke Dect In All 4 Day Rooms	2006	1,359		20	68	68	136	14
15	Sprinkler System	2006	27,280		20	1,364	1,364	2,728	15
16	Sprinkler System	2006	17,019		20	851	851	1,702	16
17	Doors Lsc	2006	2,030		20	102	102	203	17
18	Doors Lsc	2006	2,145		20	107	107	215	18
19	Door Closer	2006	2,108		20	105	105	210	19
20	Wall Covering	2006	2,480		20	124	124	248	20
21	Installation & Cost 3 Smoke Detectors	2007	1,381		20	59	59	59	21
22	Sprinkler System	2007	14,399		20	613	613	613	22
23	(4) Photoelectric Smoke Dectectors	2007	145		20	6	6	6	23
24	Architect Sprinkler System	2007	3,040		20	115	115	115	24
25	Sprinkler System	2007	12,966		20	490	490	490	25
26	Fire Alarm Panel Upgrade For Sprinkler System	2007	1,850		20	70	70	70	26
27	1-Water Heater	2007	17,797		20	605	605	605	27
28	Consulting Engineer A/C Unit	2007	3,360		20	114	114	114	28
29	Smoke Detectors Center Core	2007	1,070		20	36	36	36	29
30	Duct Smoke Detectors	2007	15,730		20	534	534	534	30
31	A/C Plan Review	2007	3,971		20	123	123	123	31
32	A/C Design	2007	11,520		20	303	303	303	32
33	Remove&Replace Side Walk And Gutter	2007	1,200		20	32	32	32	33
34	TOTAL (lines 1 thru 33)		\$ 4,883,258	\$ 236,351		\$ 147,341	\$ (89,010)	\$ 3,024,535	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:

12/01/07

Ending:

11/30/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,883,258	\$ 236,351		\$ 147,341	\$ (89,010)	\$ 3,024,535	1
2	Labor And Materials For Hot Water Heater (Materials \$1559.30) R	2007	3,755		20	99	99	99	2
3	Consulting A/C System	2007	5,760		20	106	106	106	3
4	1 Door For New Employee Entrance Wing 1	2007	2,223		20	29	29	29	4
5	Asbestos Removal	2007	4,800		20	62	62	62	5
6	Consulting For A/C	2007	750		20	7	7	7	6
7	Partial Payment A/C Roof Top Unit	2007	60,720		20	549	549	549	7
8	Under Ground Main Sewer Line Repair	2007	2,586		20	13	13	13	8
9	Under Ground Main Sewer Line Repair	2007	1,333		20	7	7	7	9
10	Under Ground Main Sewer Line Repair	2007	1,963		20	10	10	10	10
11	Roof Top Unit Compressor And Coil	2007	4,841		20	25	25	25	11
12	Labor To Install Damper	2007	960		20	5	5	5	12
13	Labor To Install Wiring Harness	2007	106		20	1	1	1	13
14	Install 14 Smoke Detectors	2007	4,200		20	22	22	22	14
15	Install Add 14 Smoke Detectors	2007	4,200		20	22	22	22	15
16	Install Add 9 Smoke Detectors	2007	2,700		20	14	14	14	16
17	Partial Pay New A/C Replacement	2007	114,778		20	597	597	597	17
18	Additional Invoices From Main Sewer Line Work	2007	58		20	0	0	0	18
19	Additional Invoices From Main Sewer Line Work	2007	254		20	0	0	0	19
20	Purchase Of Water Softner	2007	10,650		20	4	4	4	20
21	Partial Pay Replace A/C System	2007	157,192		20	65	65	65	21
22	Roof Top Ac Repair	2007	3,092		20	57	57	57	22
23	Painting Of Center Core And Corridors	2007	4,800		20	62	62	62	23
24	Air Conditioning	2008	147,875		20	3,099	3,099	3,099	24
25	Smoking Shelter	2008	5,276		20	111	111	111	25
26	Boiler Tank	2008	11,136		20	233	233	233	26
27	Steam Distributing Coils	2008	2,730		20	57	57	57	27
28	Additional Costs Of Air Conditioner Replacment	2008	27,395		20	3,265	3,265	3,265	28
29	Remodel Center Core - Wallcovering, Carpet, Cabinets, Painting	2008	16,286		20	225	225	225	29
30	Remodel Front Entrance - Reception, Granite For Lobby, Front Do	2008	15,245		20	79	79	79	30
31	Remove And Replace Soffits On Building	2008	171,492		20	23	23	23	31
32	Call Lights	2008	563		20	0	0	0	32
33	Walk In Freezer	2008	227		20	9	9	9	33
34	TOTAL (lines 1 thru 33)		\$ 5,673,205	\$ 236,351		\$ 156,199	\$ (80,152)	\$ 3,033,394	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:

12/01/07

Ending:

11/30/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 5,673,205	\$ 236,351		\$ 156,199	\$ (80,152)	\$ 3,033,394	1
2	Wiring For Parking Lot Lights	2008	340		20	14	14	14	2
3	Condensate Return Unit	2008	968		20	40	40	40	3
4	Condensate Pump Motor	2008	132		20	6	6	6	4
5	Main Line Plug	2008	615		20	26	26	26	5
6	Main Line Plug	2008	85		20	4	4	4	6
7	Mop Sink	2008	582		20	24	24	24	7
8	Controller For Whole House Water Heater	2008	1,072		20	45	45	45	8
9	Kitchen Disposal	2008	2,456		20	82	82	82	9
10	Call Lights	2008	47		20	1	1	1	10
11	Nurse Call Light Adapter	2008	92		20	3	3	3	11
12	Call Lights	2008	618		20	18	18	18	12
13	Repair Bypass Electrical For Backup Generator	2008	454		20	13	13	13	13
14	Call Lights	2008	185		20	5	5	5	14
15	Call Lights	2008	212		20	5	5	5	15
16	Call Lights	2008	183		20	5	5	5	16
17	Repair Concrete Pillars Front Drive	2008	183		20	5	5	5	17
18	Duct Work In Basement	2008	82		20	2	2	2	18
19	Duct Work In Basement	2008	83		20	2	2	2	19
20	Fire Barrier Sealant	2008	269		20	6	6	6	20
21	Fire Barrier Sealant	2008	403		20	9	9	9	21
22	Fire Barrier Sealant	2008	403		20	9	9	9	22
23	Door Alarms	2008	180		20	4	4	4	23
24	Door Alarms	2008	30		20	1	1	1	24
25	Pa Amplifier	2008	127		20	2	2	2	25
26	Repair Generator	2008	2,104		20	35	35	35	26
27	Repair Generator	2008	27		20	0	0	0	27
28	Repair Generator	2008	54		20	1	1	1	28
29	Repair Generator	2008	64		20	1	1	1	29
30	Front Office Sign	2008	45		20	1	1	1	30
31	Hvac Repairs	2008	1,826		20	31	31	31	31
32	Hvac Repairs	2008	439		20	7	7	7	32
33	New Toilet	2008	203		20	3	3	3	33
34	TOTAL (lines 1 thru 33)		\$ 5,687,768	\$ 236,351		\$ 156,609	\$ (79,742)	\$ 3,033,803	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:

12/01/07

Ending:

11/30/08

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 12G, Carried Forward		\$ 5,687,768	\$ 236,351		\$ 156,609	\$ (79,742)	\$ 3,033,803	1
2	Store Room Door Lever	2008	115		20	2	2	2	2
3	Fire Barrier Sealant	2008	140		20	2	2	2	3
4	Emergency Generator Replacement	2008	2,875		20	48	48	48	4
5	Rooftop A/C Unit And Ductwork	2008	3,500		20	59	59	59	5
6	Concrete Removal/Replacement In Fire Lane	2008	4,900		20	83	83	83	6
7	Remove/Replace Ramp To Back Door	2008	3,600		20	45	45	45	7
8	Outside Lighting	2008	25		20	0	0	0	8
9	Outside Lighting	2008	20		20	0	0	0	9
10	Outside Lighting	2008	4		20	0	0	0	10
11	Door Alarms	2008	81		20	1	1	1	11
12	Door Alarms	2008	81		20	1	1	1	12
13	Hand Rails For Lsc	2008	183		20	2	2	2	13
14	Outside Lighting	2008	38		20	0	0	0	14
15	Hand Rails For Lsc	2008	103		20	1	1	1	15
16	Door Alarms & Hardware	2008	172		20	1	1	1	16
17	New Ramp For Lsc	2008	42		20	0	0	0	17
18	Outside Lighting	2008	20		20	0	0	0	18
19	Bucket Life To Install Outside Lighting	2008	125		20	1	1	1	19
20	Door Alarms	2008	1,740		20	15	15	15	20
21	Boiler Repair	2008	511		20	4	4	4	21
22	Hot Water Heater Repair	2008	221		20	2	2	2	22
23	Alarm-Yardguard Gate	2008	50		20	0	0	0	23
24	Lsc Hand Rails	2008	71		20	0	0	0	24
25	Alarm	2008	14		20	0	0	0	25
26	Lsc Hand Rails	2008	122		20	0	0	0	26
27	Thermostat For Hot Water Heater	2008	80		20	0	0	0	27
28	Manlift Rental For Installing Smoke Detectors In Center Core	2008	88		20	0	0	0	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	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:

12/01/07

Ending:

11/30/08

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	Totals from Page 12H, Carried Forward		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	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:

12/01/07

Ending:

11/30/08

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	Totals from Page 12I, Carried Forward		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	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:

12/01/07

Ending:

11/30/08

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 12J, Carried Forward		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	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:

12/01/07

Ending:

11/30/08

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	Totals from Page 12K, Carried Forward		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	1
2									2
3									3
4									4
5									5
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	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:

12/01/07

Ending:

11/30/08

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 12L, Carried Forward		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	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:

12/01/07

Ending:

11/30/08

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	Totals from Page 12M, Carried Forward		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	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:

12/01/07

Ending:

11/30/08

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	Totals from Page 12N, Carried Forward		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	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:

12/01/07

Ending:

11/30/08

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	Totals from Page 12O, Carried Forward		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	1
2									2
3									3
4									4
5									5
6									6
7									7
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9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	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:

12/01/07

Ending:

11/30/08

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	Totals from Page 12P, Carried Forward		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,706,688	\$ 236,351		\$ 156,878	\$ (79,473)	\$ 3,034,072	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:

12/01/07

Ending:

11/30/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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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:

12/01/07

Ending:

11/30/08

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							
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67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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

0010561

Report Period Beginning:

12/01/07

Ending:

11/30/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

0010561

Report Period Beginning:

12/01/07

Ending:

11/30/08

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)	\$	\$		\$	\$	\$	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: 12/01/07 Ending: 11/30/08

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	\$ 957,682	\$	\$ 90,362	\$ 90,362	10	\$ 523,555	71
72	Current Year Purchases	104,621		3,717	3,717	10	3,717	72
73	Fully Depreciated Assets	327,648				10	327,648	73
74								74
75	TOTALS	\$ 1,389,951	\$	\$ 94,079	\$ 94,079		\$ 854,920	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)	\$ 7,359,526	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 236,351	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 266,644	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 30,293	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,963,905	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 3,796 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

12/01/07 Ending:

11/30/08

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	\$		\$	79,082		\$	79,082	1
2	Licensed Speech and Language Development Therapist	39 - 02	hrs				5,985			5,985	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 02	hrs				90,671			90,671	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				90,253			90,253	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): See Supplemental						29,482			29,482	13
14	TOTAL			\$		\$	295,473		\$	295,473	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 # 0010561 Report Period Beginning: 12/01/07 Ending: 11/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/08 (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	\$ 415,410	\$	1
2	Cash-Patient Deposits	18,033		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	768,428		3
4	Supply Inventory (priced at)	62,356		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): <u>See Attached Schedule</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,264,227	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	80,568		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	7,084,149		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(4,222,652)		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): <u>See Attached Schedule</u>	714,699		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,656,764	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,920,991	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 141,781	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,033		28
29	Short-Term Notes Payable	2,794		29
30	Accrued Salaries Payable	274,929		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 437,537	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 437,537	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,483,454	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,920,991	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,942,014	1
2	Restatements (describe):		2
3	Audit Adjustments to Revenue & Expenses	202,559	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,144,573	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	338,881	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 338,881	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,483,454	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home# 0010561Report Period Beginning: 12/01/07Ending: 11/30/08**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	\$ 5,974,885	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,974,885	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,088	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,088	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	46,577	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46,577	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	752,463	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 752,463	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,777,013	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,506,238	31
32	Health Care	3,238,812	32
33	General Administration	915,035	33
B. Capital Expense			
34	Ownership	240,790	34
C. Ancillary Expense			
35	Special Cost Centers	452,711	35
36	Provider Participation Fee	84,546	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,438,132	40
41	Income before Income Taxes (line 30 minus line 40)**	338,881	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 338,881	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: 12/01/07

Ending: 11/30/08

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	1,890	2,080	\$ 65,691	\$ 31.58	1
2	Assistant Director of Nursing	1,456	1,664	48,830	29.34	2
3	Registered Nurses	11,399	12,026	312,402	25.98	3
4	Licensed Practical Nurses	35,455	37,407	761,140	20.35	4
5	CNAs & Orderlies	105,355	119,909	1,630,558	13.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,824	2,080	28,648	13.77	9
10	Activity Assistants	4,370	5,250	56,072	10.68	10
11	Social Service Workers	3,940	4,272	97,768	22.89	11
12	Dietician					12
13	Food Service Supervisor	3,565	4,163	52,462	12.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,041	30,227	324,330	10.73	15
16	Dishwashers					16
17	Maintenance Workers	9,388	10,790	134,135	12.43	17
18	Housekeepers	14,270	17,479	191,176	10.94	18
19	Laundry	5,852	6,694	70,136	10.48	19
20	Administrator	1,816	2,080	83,197	40.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,501	12,608	149,759	11.88	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>	2,759	3,203	41,805	13.05	33
34	TOTAL (lines 1 - 33)	242,881	271,931	\$ 4,048,109 *	\$ 14.89	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	282	\$ 11,285	01-03	35
36	Medical Director	Monthly	9,750	09-03	36
37	Medical Records Consultant	45	2,226	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	69	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,180	11-03	44
45	Social Service Consultant	30	1,180	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	389	\$ 30,490		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	628	25,112	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	628	\$ 25,112		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Knox County Nursing Home

0010561

Report Period Beginning: 12/01/07

Ending: 11/30/08

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		
Marianne Wiesen	Administrator	0	\$ 83,197	Workers' Compensation Insurance	\$ 95,922	IDPH License Fee	\$		
				Unemployment Compensation Insurance	51,219	Advertising: Employee Recruitment	1,325		
				FICA Taxes	303,977	Health Care Worker Background Check			
				Employee Health Insurance	380,068	(Indicate # of checks performed <u>75</u>)	750		
				Employee Meals		Patient Background Checks <u>85</u>	850		
				Illinois Municipal Retirement Fund (IMRF)*	319,238	Dues & Subscriptions	4,573		
				Employee Incentives	5,314	Med Forms/Publications	2,184		
						County Nursing Home Association	1,220		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 83,197						
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
	\$					\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	6,314	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type	Amount							
Frost, Ruttenberg & Rothblatt	Accounting	\$ 7,845							
Carpentier Mitchell Goddard	Accounting	11,984							
Achieve Software Corp.	Computer Services	938							
State's Atty Appealate Prosecutor	Legal	1,560							
TOTAL (agree to Schedule V, line 19, column 3)			\$ 22,327						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Knox County Nursing Home

Report Period Beginning: 12/01/07 Ending: 11/30/08

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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
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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 - \$1,220
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (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. \$ 37,700 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. \$ 84,546
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. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 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? 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? 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 Available
- (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.

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