

Facility Name & ID Number KNOX ESTATES

0024265 Report Period Beginning: 07/01/08 Ending: 06/30/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,580			5,580	13
14	TOTALS	5,580			5,580	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.55%

D. How many bed-hold days during this year were paid by the Department? 123 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 01/05/1980

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: EXEMPT Fiscal Year: 06/30

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

Facility Name & ID Number **KNOX ESTATES** # **0024265** Report Period Beginning: **07/01/08** Ending: **06/30/09**

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	23,995	2,609	1,113	27,717		27,717		27,717		1
2	Food Purchase		36,781		36,781		36,781		36,781		2
3	Housekeeping	12,179	2,273		14,452		14,452		14,452		3
4	Laundry		4,231		4,231		4,231		4,231		4
5	Heat and Other Utilities			24,223	24,223		24,223	(2,457)	21,766		5
6	Maintenance	9,925	9,392		19,317		19,317		19,317		6
7	Other (specify):*										7
8	TOTAL General Services	46,099	55,286	25,336	126,721		126,721	(2,457)	124,264		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	227,917	8,340	2,551	238,808		238,808		238,808		10
10a	Therapy			218	218		218		218		10a
11	Activities		8,445	1,014	9,459		9,459		9,459		11
12	Social Services			942	942		942		942		12
13	CNA Training	6,666	172		6,838		6,838		6,838		13
14	Program Transportation		7,767		7,767		7,767		7,767		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	234,583	24,724	4,725	264,032		264,032		264,032		16
	C. General Administration										
17	Administrative	73,639			73,639		73,639	107,678	181,317		17
18	Directors Fees										18
19	Professional Services			1,600	1,600		1,600		1,600		19
20	Dues, Fees, Subscriptions & Promotions			45	45		45		45		20
21	Clerical & General Office Expenses		7,567		7,567		7,567		7,567		21
22	Employee Benefits & Payroll Taxes			92,848	92,848		92,848		92,848		22
23	Inservice Training & Education										23
24	Travel and Seminar			846	846		846		846		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,317	3,317		3,317		3,317		26
27	Other (specify):*										27
28	TOTAL General Administration	73,639	7,567	98,656	179,862		179,862	107,678	287,540		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	354,321	87,577	128,717	570,615		570,615	105,221	675,836		29

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

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

Facility Name & ID Number

KNOX ESTATES

#0024265

Report Period Beginning:

07/01/08

Ending:

06/30/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			13,893	13,893		13,893	(5,408)	8,485			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Asset Sale Loss			1,539	1,539		1,539		1,539			36
37	TOTAL Ownership			15,432	15,432		15,432	(5,408)	10,024			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			38,759	38,759		38,759		38,759			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			38,759	38,759		38,759		38,759			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	354,321	87,577	182,908	624,806		624,806	99,813	724,619			45

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

KNOX ESTATES

ID# 0024265

Report Period Beginning: 07/01/08

Ending: 06/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number KNOX ESTATES

0024265

Report Period Beginning:

07/01/08

Ending:

06/30/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,457)	0	0	0	0	0	0	0	0	0	0	(2,457)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,457)	0	(2,457)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	107,678	0	0	0	0	0	0	0	0	0	0	107,678	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	107,678	0	107,678	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	105,221	0	105,221	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number KNOX ESTATES# 0024265

Report Period Beginning:

07/01/08

Ending:

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(5,408)	0	0	0	0	0	0	0	0	0	0	(5,408)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,408)	0	0	0	0	0	0	0	0	0	0	(5,408)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	99,813	0	0	0	0	0	0	0	0	0	0	99,813	45

Facility Name & ID Number

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VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
STREATOR UNLIMITED	100%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number

KNOX ESTATES

#

0024265

Report Period Beginning:

07/01/08

Ending:

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number KNOX ESTATES

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ALLOWABLE ADMIN. COSTS	DIRECT BUDGETED COST	1,994,052	6	\$ 329,041	\$ 184,669	652,550	\$ 107,678	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					\$ 329,041	\$ 184,669		\$ 107,678	25

Facility Name & ID Number

KNOX ESTATES

0024265

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,004 B. General Construction Type: Exterior BRICK VENEER Frame WOOD Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>RESIDENTIAL</u>	<u>211,540</u>	<u>1976</u>	<u>\$ 26,838</u>	<u>1</u>
2	<u>IDLE</u>	<u>229,115</u>		<u>6,232</u>	<u>2</u>
3	TOTALS	440,655		\$ 33,070	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1980	1980	\$ 347,142	\$		\$	\$	\$ 347,142
5									
6									
7									
8									
Improvement Type**									
9	ASPHALT ROAD		1986	488		20			488
10	CONNEX BROS.		1986	2,229		20			2,229
11	ELECTRICAL		1987	10,483		20			10,483
12	TILING		1987	828		20			828
13	ADDITION		1992	6,623		10			6,623
14	SOIL BORING & PERCOLATING TESTING		1994	1,252	52	15	52		1,252
15	SEWER TILE & LEACH FIELD REMOVAL & REPLACEMENT		1995	26,909	1,794	15	1,794		25,997
16	FLOORING		1996	1,083		10			1,083
17	FLOOR TILE & MOLDING		2001	2,110	106	20	106		826
18	ROOF		2001	30,600	1,530	20	1,530		11,794
19	FLOORING		2004	2,345	117	20	117		649
20	CARPETING		2005	4,265	213	20	213		755
21	FURNACE		2008	3,450	173	20	173		238
22	FIRE SPRINKLER SYSTEM		2009	17,338	614	20	614		614
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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)	\$ 457,145	\$ 4,599		\$ 4,599	\$	\$ 411,001	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 22,793	\$ 3,237	\$ 3,237	\$		\$ 15,921	71
72	Current Year Purchases	5,367	537	537			537	72
73	Fully Depreciated Assets	60,339					60,339	73
74								74
75	TOTALS	\$ 88,499	\$ 3,774	\$ 3,774	\$		\$ 76,797	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 578,714	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,373	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 8,373	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 487,798	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	1996 DODGE RAM VAN	\$ 29,580	\$	\$ 29,580	86
87	2005 CHEVY VENTURE	21,484	4,297	19,336	87
88	2004 FORD ECONOLINE	6,000	600	600	88
89					89
90					90
91	TOTALS	\$ 57,064	\$ 4,897	\$ 49,516	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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>DSP'S WERE TRAINED</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		172		172
3	Classroom Wages (a)		1,756		1,756
4	Clinical Wages (b)		3,801		3,801
5	In-House Trainer Wages (c)		1,109		1,109
6	Transportation				
7	Contractual Payments			150	150
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,838	\$ 150	\$ 6,988
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,838		

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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

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

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

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

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

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

Facility Name & ID Number **KNOX ESTATES**# **0024265**Report Period Beginning: **07/01/08**

Ending:

06/30/09**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **06/30/09**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 189,468	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance NONE)	185,850	262,948	3
4	Supply Inventory (priced at COST)		20,450	4
5	Short-Term Investments			5
6	Prepaid Insurance		15,638	6
7	Other Prepaid Expenses		4,529	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 185,850	\$ 493,033	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		13,290	12
13	Land	33,070	89,020	13
14	Buildings, at Historical Cost	457,145	1,764,810	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	145,563	1,011,589	16
17	Accumulated Depreciation (book methods)	(537,314)	(1,947,618)	17
18	Deferred Charges		66,404	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 98,464	\$ 997,495	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 284,314	\$ 1,490,528	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,222	\$ 12,903	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,805	124,711	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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 45,027	\$ 137,614	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		498,134	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 498,134	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 45,027	\$ 635,748	46
47	TOTAL EQUITY(page 18, line 24)	\$ 239,287	\$ 854,780	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 284,314	\$ 1,490,528	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 226,952	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 226,952	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	90,308	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Allocated Indirect Costs (Sch. VIII)	(107,678)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (17,370)	17
	B. Transfers (Itemize):		
18	STREATOR UNLIMITED, INC	29,705	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 29,705	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 239,287	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **KNOX ESTATES**# **0024265**Report Period Beginning: **07/01/08**Ending: **06/30/09**

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	\$ 686,584	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 686,584	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	8,340	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	200	15
16	Rental of Facility Space	2,100	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)	\$ 10,640	23
D. Non-Operating Revenue			
24	Contributions	14,370	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,370	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING & RECYCLING	270	28
28a	STIMULUS PROCEEDS	3,250	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,520	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 715,114	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	126,721	31
32	Health Care	264,032	32
33	General Administration	179,862	33
B. Capital Expense			
34	Ownership	15,432	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	38,759	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 624,806	40
41	Income before Income Taxes (line 30 minus line 40)**	90,308	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 90,308	43

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

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

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

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

Facility Name & ID Number **KNOX ESTATES**

0024265

Report Period Beginning:

07/01/08

Ending:

06/30/09

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	679	827	17,156	20.74	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,753	1,983	18,299	9.23	14
15	Cook Helpers/Assistants	687	695	5,696	8.20	15
16	Dishwashers					16
17	Maintenance Workers	468	543	9,925	18.28	17
18	Housekeepers	1,392	1,562	12,179	7.80	18
19	Laundry					19
20	Administrator	1,220	1,456	30,636	21.04	20
21	Assistant Administrator	1,350	1,505	24,896	16.54	21
22	Other Administrative	881	1,020	18,107	17.75	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,062	1,293	26,834	20.75	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	17,376	18,827	181,773	9.65	30
31	Medical Records	522	649	8,820	13.59	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	27,390	30,360	\$ 354,321 *	\$ 11.67	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	14	\$ 1,113		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	4	200		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	218		43
44	Activity Consultant	12	868		44
45	Social Service Consultant	9	942		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	42	\$ 3,341		49

C. CONTRACT NURSES

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

Facility Name & ID Number KNOX ESTATES

0024265

Report Period Beginning: 07/01/08

Ending: 06/30/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 955 Line 4
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,759
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. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 17,919
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: MASON ACCOUNTING GROUP, LLC
- (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.

KNOX ESTATES/STREATOR UNLIMITED, INC.

#0024265

PAGE 21 ATTACHMENT

JULY 1, 2008 - JUNE 30, 2009

PAGE 21, SECTION XIX, PART G.

<u>DATE</u>	<u>INDIVIDUAL</u>	<u>TITLE</u>	<u>SEMINAR TITLE</u>	<u>LOCATION</u>	<u>SPONSOR</u>	<u>COST</u>	<u>DESCRIPTION</u>
7/16/2008	Michelle Jakupcak	DSP III	NEMT Safety	Chicago, IL	Medicarsafety.com	\$ 2.28	Travel
5/8/2009	Mike Cinnamon	Maintenance	RTAC Safety	Kankakee, IL	RTAC	\$ 1.75	Travel
9/15/2008	Michelle Jakupcak	DSP III	Activity Director Training	Fairbury, IL	Corn Belt Activity Directors Association	\$ 18.95	Travel
11/19/2008	Teri Bradley	Consumer Benefits Advocate	DSP Course Coordinator	Tinley Park, IL	Department of Human Services	\$ 52.94	Travel
In-State Travel Total						<u>\$ 75.92</u>	
4/7/2009	Ronda Schmitz	Cook Consumer Benefits Advocate	CPI Training Community Residential Providers	Streator, IL	Streator Unlimited Community Residential Providers	\$ 14.46	Seminar Cost
6/11/2009	Teri Bradley	Advocate	Providers	Park Ridge, IL	American Red Cross of the Heartland	\$ 12.25	Seminar Cost
6/16/2008	Steve Booze	DSP I	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 25.00	Seminar Cost
6/16/2008	Leslie Crum	DSP I	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 25.00	Seminar Cost
6/16/2008	Patty Berninger	DSP I	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 25.00	Seminar Cost
6/16/2008	Lucy Quick	DSP I	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 25.00	Seminar Cost
7/14/2008	Steve Booze	DSP I	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 25.00	Seminar Cost
7/14/2008	Marlene Kozak	DSP II	First Aid Training	Streator, IL	Heartland	\$ 25.00	Seminar Cost
7/16/2008	Michelle Jakupcak	DSP III	NEMT Safety	Chicago, IL	Medicarsafety.com	\$ 61.43	Seminar Cost
9/26/2008	Teri Bradley	Consumer Benefits Advocate	Legal & Future Planning	Gillman, IL	ARC of IL	\$ 22.05	Seminar Cost

KNOX ESTATES/STREATOR UNLIMITED, INC.

#0024265

PAGE 21 ATTACHMENT

JULY 1, 2008 - JUNE 30, 2009

9/26/2008	Lisa Renner	Asst. Dir. Of Res. Svs.	Legal & Future Planning	Gillman, IL	ARC of IL	\$ 31.95	Seminar Cost
10/2/2008	Marlene Eichelberg	Housekeeping	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 25.00	Seminar Cost
10/2/2008	Jesse Mesarchik	DSP I	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 25.00	Seminar Cost
10/2/2008	Will Price	DSP II	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 25.00	Seminar Cost
10/2/2008	Diana Huff	DSP II	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 12.50	Seminar Cost
10/10/2008	Michelle Jakupcak	DSP III	CPR Training	Streator, IL	St. Mary's Hospital	\$ 0.96	Seminar Cost
10/10/2008	Julie Carstens	Dir. Of Res. Svs.	CPR Training	Streator, IL	St. Mary's Hospital	\$ 2.10	Seminar Cost
10/28/2008	Julie Carstens	Dir. Of Res. Svs.	DD Facility Updates	Springfield, IL	Administrators' Assn.	\$ 125.00	Seminar Cost
11/11/2008	Maricela Pantoja	DSP I	CPR Training	Streator, IL	St. Mary's Hospital	\$ 3.00	Seminar Cost
11/11/2008	Lisa Renner	Asst. Dir. Of Res. Svs.	CPR Training	Streator, IL	St. Mary's Hospital	\$ 2.13	Seminar Cost
12/8/2008	Maricela Pantoja	DSP I	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 25.00	Seminar Cost
12/8/2008	Robert Osborn	DSP II	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 17.50	Seminar Cost
12/23/2008	Tiffany King	DSP II	CPR Training	Streator, IL	St. Mary's Hospital	\$ 3.00	Seminar Cost
12/30/2008	Amy Hogan	DSP II	CPR Training	Streator, IL	St. Mary's Hospital	\$ 3.00	Seminar Cost
3/4/2009	Teri Bradley	Consumer Benefits Advocate	Occupational Safety & Health	Peoria, IL	DIOSH	\$ 49.00	Seminar Cost
3/4/2009	Lisa Renner	Asst. Dir. Of Res. Svs.	Occupational Safety & Health	Peoria, IL	DIOSH	\$ 71.00	Seminar Cost
3/25/2009	Ronda Schmitz	Cook	Fire Extinguisher Training	Streator, IL	Streator Unlimited	\$ 8.75	Seminar Cost

KNOX ESTATES/STREATOR UNLIMITED, INC.
#0024265
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JULY 1, 2008 - JUNE 30, 2009

3/31/2009 Ronda Schmitz	Cook Asst. Dir. Of Res.	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 20.00	Seminar Cost
3/31/2009 Lisa Renner	Svs.	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 20.00	Seminar Cost
3/31/2009 Tammy Rowe	DSP III	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 20.00	Seminar Cost
3/31/2009 Jessica Stephens	DSP II	First Aid Training	Streator, IL	American Red Cross of the Heartland	<u>\$ 20.00</u>	Seminar Cost
Seminar Expense Total					<u><u>\$ 770.08</u></u>	