

		FOR BHF USE					

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

<p>I. IDPH License ID Number: <u>0024265</u></p> <p>Facility Name: <u>KNOX ESTATES</u></p> <p>Address: <u>PO BOX 706, ENGLE DRIVE</u> <u>STREATOR</u> <u>61364</u> Number City Zip Code</p> <p>County: <u>LASALLE</u></p> <p>Telephone Number: <u>(815) 673-5574</u> Fax # <u>(815) 673-1714</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/05/80</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>JOHN MALLANEY</u> Telephone Number: <u>(815) 673-5574</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/09</u> to <u>06/30/10</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>JOHN MALLANEY</u> (Title) <u>EXECUTIVE DIRECTOR</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) <u>D. KEVIN MASON</u> <u>OWNER</u> (Firm Name & Address) <u>MASON ACCOUNTING GROUP, LLC</u> <u>1025 PEORIA ST, PERU, IL 61354</u> (Telephone) <u>(815) 223-8808</u> Fax # <u>(815) 220-3529</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>JOHN MALLANEY</u> (Title) <u>EXECUTIVE DIRECTOR</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>D. KEVIN MASON</u> <u>OWNER</u> (Firm Name & Address) <u>MASON ACCOUNTING GROUP, LLC</u> <u>1025 PEORIA ST, PERU, IL 61354</u> (Telephone) <u>(815) 223-8808</u> Fax # <u>(815) 220-3529</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>JOHN MALLANEY</u> (Title) <u>EXECUTIVE DIRECTOR</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>D. KEVIN MASON</u> <u>OWNER</u> (Firm Name & Address) <u>MASON ACCOUNTING GROUP, LLC</u> <u>1025 PEORIA ST, PERU, IL 61354</u> (Telephone) <u>(815) 223-8808</u> Fax # <u>(815) 220-3529</u>							

Facility Name & ID Number KNOX ESTATES

0024265 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,840			5,840	13
14	TOTALS	5,840			5,840	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 100.00%

D. How many bed-hold days during this year were paid by the Department? 239 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

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

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

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: EXEMPT Fiscal Year: 06/30

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

Facility Name & ID Number **KNOX ESTATES** # **0024265** Report Period Beginning: **07/01/09** Ending: **06/30/10**

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	32,115	1,467	521	34,103		34,103		34,103		1
2	Food Purchase		30,903		30,903		30,903		30,903		2
3	Housekeeping	12,162	2,571		14,733		14,733		14,733		3
4	Laundry		5,672		5,672		5,672		5,672		4
5	Heat and Other Utilities			21,978	21,978		21,978	(2,368)	19,610		5
6	Maintenance	9,098	10,758		19,856		19,856		19,856		6
7	Other (specify):*										7
8	TOTAL General Services	53,375	51,371	22,499	127,245		127,245	(2,368)	124,877		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	228,490	11,580	1,927	241,997		241,997		241,997		10
10a	Therapy										10a
11	Activities		7,260	2,033	9,293		9,293		9,293		11
12	Social Services			1,126	1,126		1,126		1,126		12
13	CNA Training	6,450	129		6,579		6,579		6,579		13
14	Program Transportation		7,253		7,253		7,253		7,253		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	234,940	26,222	5,086	266,248		266,248		266,248		16
	C. General Administration										
17	Administrative	78,148			78,148		78,148	88,825	166,973		17
18	Directors Fees										18
19	Professional Services			1,620	1,620		1,620		1,620		19
20	Dues, Fees, Subscriptions & Promotions			149	149		149		149		20
21	Clerical & General Office Expenses		4,699		4,699		4,699		4,699		21
22	Employee Benefits & Payroll Taxes			63,971	63,971		63,971		63,971		22
23	Inservice Training & Education										23
24	Travel and Seminar			297	297		297		297		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			6,370	6,370		6,370		6,370		26
27	Other (specify):*										27
28	TOTAL General Administration	78,148	4,699	72,407	155,254		155,254	88,825	244,079		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	366,463	82,292	99,992	548,747		548,747	86,457	635,204		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:

07/01/09

Ending:

06/30/10

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			11,706	11,706		11,706	(3,348)	8,358			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			11,706	11,706		11,706	(3,348)	8,358			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			38,490	38,490		38,490		38,490			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			38,490	38,490		38,490		38,490			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	366,463	82,292	150,188	598,943		598,943	83,109	682,052			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: 07/01/09

Ending: 06/30/10

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:

07/01/09

Ending:

06/30/10

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	(2,368)	0	0	0	0	0	0	0	0	0	0	(2,368)	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	(2,368)	0	(2,368)	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	88,825	0	0	0	0	0	0	0	0	0	0	88,825	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	88,825	0	88,825	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	86,457	0	86,457	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number KNOX ESTATES# 0024265

Report Period Beginning:

07/01/09

Ending:

06/30/10

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	(3,348)	0	0	0	0	0	0	0	0	0	0	(3,348)	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	(3,348)	0	0	0	0	0	0	0	0	0	0	(3,348)	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)	83,109	0	0	0	0	0	0	0	0	0	0	83,109	45

Facility Name & ID Number

KNOX ESTATES

0024265

Report Period Beginning:

07/01/09

Ending:

06/30/10

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:

07/01/09

Ending:

06/30/10

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number KNOX ESTATES

0024265

Report Period Beginning:

07/01/09

Ending: 06/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	1,966,540	6	\$ 267,685	\$ 171,069	652,550	\$ 88,825	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					\$ 267,685	\$ 171,069		\$ 88,825	25

Facility Name & ID Number

KNOX ESTATES

0024265

Report Period Beginning:

07/01/09

Ending:

06/30/10

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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2009 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 2010 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:	2005	_____	8
	2006	_____	9
	2007	_____	10
	2008	_____	11
	2009	_____	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME KNOX ESTATES COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0024265

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(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 and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number KNOX ESTATES

0024265

Report Period Beginning:

07/01/09

Ending:

06/30/10

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

Facility Name & ID Number KNOX ESTATES

0024265

Report Period Beginning:

07/01/09

Ending:

06/30/10

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		15			1,252
15	SEWER TILE & LEACH FIELD REMOVAL & REPLACEMENT		1995	26,909	912	15	912		26,909
16	FLOORING		1996	1,083		10			1,083
17	FLOOR TILE & MOLDING		2001	2,110	106	20	106		932
18	ROOF		2001	30,600	1,530	20	1,530		13,324
19	FLOORING		2004	2,345	117	20	117		766
20	CARPETING		2005	4,265	213	20	213		968
21	FURNACE		2008	3,450	173	20	173		411
22	FIRE SPRINKLER SYSTEM		2009	17,338	867	20	867		1,481
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

Facility Name & ID Number **KNOX ESTATES**

0024265

Report Period Beginning:

07/01/09

Ending:

06/30/10

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
			457,145		3,918		3,918	414,919

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

Facility Name & ID Number **KNOX ESTATES**

0024265

Report Period Beginning:

07/01/09

Ending:

06/30/10

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	\$ 23,630	\$ 3,674	\$ 3,674			\$ 14,862	71
72	Current Year Purchases	10,586	766	766			766	72
73	Fully Depreciated Assets	65,609					65,609	73
74								74
75	TOTALS	\$ 99,825	\$ 4,440	\$ 4,440			\$ 81,237	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)	\$ 590,040	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 8,358	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 8,358	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)	\$ 496,156	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	2,148	21,484	87
88	2004 FORD ECONOLINE	6,000	1,200	1,800	88
89					89
90					90
91	TOTALS	\$ 57,064	\$ 3,348	\$ 52,864	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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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		129		129
3	Classroom Wages (a)		1,521		1,521
4	Clinical Wages (b)		2,560		2,560
5	In-House Trainer Wages (c)		2,369		2,369
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,579	\$	\$ 6,579
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,579		

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.

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: **07/01/09**

Ending: **06/30/10**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/10**

(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	\$	\$ 371,898	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>NONE</u>)	188,029	320,204	3
4	Supply Inventory (priced at <u>COST</u>)		20,338	4
5	Short-Term Investments			5
6	Prepaid Insurance		22,249	6
7	Other Prepaid Expenses		4,111	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 188,029	\$ 738,800	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		6,000	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	156,889	1,022,322	16
17	Accumulated Depreciation (book methods)	(549,020)	(2,004,146)	17
18	Deferred Charges		64,280	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)	\$ 98,084	\$ 942,286	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 286,113	\$ 1,681,086	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 4,411	\$ 14,583	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		23	29
30	Accrued Salaries Payable	39,952	132,074	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>Payroll Withholdings</u>	472	1,560	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 44,835	\$ 148,240	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		450,400	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)	\$	\$ 474,072	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 44,835	\$ 622,312	46
47	TOTAL EQUITY(page 18, line 24)	\$ 241,278	\$ 1,058,774	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 286,113	\$ 1,681,086	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 239,287	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 239,287	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	113,120	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)	(88,825)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 24,295	17
	B. Transfers (Itemize):		
18	STREATOR UNLIMITED INC	(22,304)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (22,304)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 241,278	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **KNOX ESTATES**# **0024265**Report Period Beginning: **07/01/09**Ending: **06/30/10**

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	\$ 709,575	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 709,575	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	270	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,326	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)	\$ 1,596	23
D. Non-Operating Revenue			
24	Contributions	543	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 543	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING & RECYCLING	255	28
28a	MISCELLANEOUS	94	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 349	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 712,063	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	127,245	31
32	Health Care	266,248	32
33	General Administration	155,254	33
B. Capital Expense			
34	Ownership	11,706	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	38,490	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 598,943	40
41	Income before Income Taxes (line 30 minus line 40)**	113,120	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 113,120	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:

07/01/09

Ending:

06/30/10

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	653	811	18,049	22.26
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	1,368	1,622	15,922	9.82
15	Cook Helpers/Assistants	1,719	1,819	16,193	8.90
16	Dishwashers				16
17	Maintenance Workers	392	460	9,098	19.78
18	Housekeepers	1,271	1,435	12,162	8.48
19	Laundry				19
20	Administrator	1,263	1,456	32,611	22.40
21	Assistant Administrator	1,321	1,477	26,771	18.13
22	Other Administrative	814	976	18,766	19.23
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,022	1,269	28,229	22.25
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	15,201	17,022	178,170	10.47
31	Medical Records	657	740	10,492	14.18
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	25,681	29,087	\$ 366,463 *	\$ 12.60

* 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	8	\$ 521	35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	22	1,543	44
45	Social Service Consultant	17	1,126	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	47	\$ 3,190	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: 07/01/09

Ending: 06/30/10

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. \$ 3,250 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. \$ 38,490
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. \$ 18,695
- (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, 2009 - JUNE 30, 2010

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>
3/24/2010	Julie Carstens	Director of Res. Svs	Best Practices Conference	Streator, IL	IPD	\$ 9.00	Travel
In-State Travel Total						\$ 9.00	
10/28/2009	Becky Bruce	DSP II	CPR Training	Streator, IL	St. Mary's Hospital	\$ 5.00	Seminar Cost
1/11/2010	Adam Vance	DSP II	CPR Training	Streator, IL	St. Mary's Hospital	\$ 5.00	Seminar Cost
1/11/2010	Brandi Schultz	DSP II	CPR Training	Streator, IL	St. Mary's Hospital	\$ 5.00	Seminar Cost
4/20/2010	Jessica Stephens	DSP II	CPR Training	Streator, IL	St. Mary's Hospital	\$ 5.00	Seminar Cost
4/20/2010	Mariene Kozak	DSP II	CPR Training	Streator, IL	St. Mary's Hospital	\$ 5.00	Seminar Cost
		Consumer Benefits					
3/11/2010	Teri Bradley	Advocate	Louder Than Words	Streator, IL	Streator Unlimited	\$ 65.00	Seminar Cost
8/18/2009	Karen Crabtree	QMRP II	CPR Renewal	Streator, IL	St. Mary's Hospital	\$ 30.00	Seminar Cost
9/16/2006	Karen Austin	QMRP I	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 9.00	Seminar Cost
9/16/2009	Jeanne Hirkala	DSP I	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 9.00	Seminar Cost
9/16/2009	Mary Kay Hoffmeyer	DSP I	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 8.00	Seminar Cost
9/16/2009	Michelle Jakupcak	DSP III	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 8.00	Seminar Cost

9/16/2009	Jeannette Palaschak	DSP II	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 8.00	Seminar Cost
9/16/2009	Crystal Palko	DSP II	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 8.00	Seminar Cost
2/2/2010	Brandi Schultz	DSP II	First Aid Training	Streator, IL	American Red Cross of the Heartland	\$ 20.00	Seminar Cost
2/17/2010	Teri Bradley	Consumer Benefits Advocate	American Red Cross Certified	Bloomington, IL	American Red Cross of the Heartland	<u>\$ 98.00</u>	Seminar Cost
Seminar Expense Total						<u><u>\$ 288.00</u></u>	