

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: <u>0010561</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Knox County Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/11</u> to <u>11/30/12</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>800 North Market Street</u> <u>Knoxville</u> <u>61448</u>																																																	
Number City Zip Code																																																	
County: <u>Knox</u>																																																	
Telephone Number: <u>(309)289-2338</u> Fax # <u>(309)289-8255</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Andrew B. Cutler</u></td></tr><tr><td>(Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor Bannockburn, IL 60015</u></td></tr><tr><td>(Telephone) <u>(847) 374-0400</u> Fax # <u>(847) 374-0420</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Andrew B. Cutler</u>	(Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor Bannockburn, IL 60015</u>	(Telephone) <u>(847) 374-0400</u> Fax # <u>(847) 374-0420</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																				
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Date of Initial License for Current Owners: <u>10/23/1946</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☒</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☒</td><td>County</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td>_____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td>_____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Trust</td><td>☐</td><td>_____</td></tr><tr><td>☐</td><td></td><td>☐</td><td>Other</td><td>☐</td><td>_____</td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☒	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☒	County	☐		☐	Corporation	☐	Other _____	☐		☐	"Sub-S" Corp.	☐	_____	☐		☐	Limited Liability Co.	☐	_____	☐		☐	Trust	☐	_____	☐		☐	Other	☐	_____
☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☒	GOVERNMENTAL																																												
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☐		☐	Trust	☐	_____																																												
☐		☐	Other	☐	_____																																												
IRS Exemption Code _____																																																	
In the event there are further questions about this report, please contact:																																																	
Name: <u>Andrew Cutler</u> Telephone Number: <u>(847) 940-3269</u>																																																	
Email Address: _____																																																	

#	0010561	Report Period Beginning:	12/01/11	Ending:	11/30/12
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D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 08/28/1966

YES ☐ Date _____ NO ☒

YES ☒ NO ☐ If YES, enter number

of beds certified **169** **and days of care provided** **4,364**

IV. ACCOUNTING BASIS

MODIFIEDACCRUAL X

CASH*	
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CASH* ☐

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

Tax Year: 11/30 **Fiscal Year:** 11/30

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

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			4,364	4,364	8
9	SNF/PED					9
10	ICF	27,271	14,498	1,769	43,538	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,271	14,498	6,133	47,902	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)	77.66%
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Facility Name & ID Number Knox County Nursing Home # 0010561 Report Period Beginning: 12/01/11 Ending: 11/30/12

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	413,014	31,428	10,451	454,893		454,893		454,893			1
2	Food Purchase		305,776		305,776		305,776	(8,280)	297,496			2
3	Housekeeping	213,177	33,690		246,867		246,867		246,867			3
4	Laundry	71,898	22,718	64,384	159,000		159,000		159,000			4
5	Heat and Other Utilities			229,294	229,294		229,294		229,294			5
6	Maintenance	105,945	2,418	153,306	261,669		261,669	(20,148)	241,521			6
7	Other (specify):*											7
8	TOTAL General Services	804,034	396,030	457,435	1,657,499		1,657,499	(28,428)	1,629,071			8
	B. Health Care and Programs											
9	Medical Director			9,312	9,312		9,312		9,312			9
10	Nursing and Medical Records	3,667,349	158,453	10,965	3,836,767		3,836,767		3,836,767			10
10a	Therapy		2,240	104	2,344		2,344		2,344			10a
11	Activities	119,735	4,647	806	125,188		125,188		125,188			11
12	Social Services	122,536	758		123,294		123,294		123,294			12
13	CNA Training											13
14	Program Transportation			5,428	5,428		5,428		5,428			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,909,620	166,098	26,615	4,102,333		4,102,333		4,102,333			16
	C. General Administration											
17	Administrative	76,019			76,019		76,019		76,019			17
18	Directors Fees											18
19	Professional Services			48,413	48,413		48,413	(21,385)	27,028			19
20	Dues, Fees, Subscriptions & Promotions			40,769	40,769		40,769	(7,924)	32,845			20
21	Clerical & General Office Expenses	187,345	14,859	26,386	228,590		228,590	31,183	259,773			21
22	Employee Benefits & Payroll Taxes			895,371	895,371		895,371	892,052	1,787,423			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,099	8,099		8,099		8,099			24
25	Other Admin. Staff Transportation			2,249	2,249		2,249		2,249			25
26	Insurance-Prop.Liab.Malpractice			21,516	21,516		21,516		21,516			26
27	Other (specify):*											27
28	TOTAL General Administration	263,364	14,859	1,042,803	1,321,026		1,321,026	893,926	2,214,952			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,977,018	576,987	1,526,853	7,080,858		7,080,858	865,498	7,946,356			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.

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			285,146	285,146		285,146	(4,526)	280,620			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			1,327	1,327		1,327		1,327			35
36	Other (specify):*											36
37	TOTAL Ownership			286,473	286,473		286,473	(4,526)	281,947			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		208,876	562,098	770,974		770,974		770,974			39
40	Barber and Beauty Shops	21,268	1,580		22,848		22,848	(3,558)	19,290			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			334,278	334,278		334,278		334,278			42
43	Other (specify):*			957	957		957	(957)				43
44	TOTAL Special Cost Centers	21,268	210,456	897,333	1,129,057		1,129,057	(4,515)	1,124,542			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,998,286	787,443	2,710,659	8,496,388		8,496,388	856,457	9,352,845			45

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,280)	02		4
5	Telephone, TV & Radio in Resident Rooms	(4,505)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,526)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,594)	21		24
25	Fund Raising, Advertising and Promotional	(7,924)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(46,130)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (75,959)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	932,416		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 932,416		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 856,457		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Barber & Beauty	\$ (3,558)	40	1
2	Bank Charges	(82)	21	2
3	Current Farm Taxes	(957)	43	3
4	Non-Allowable Legal	(21,385)	19	4
5	Capitalized R&M (Net)	(20,148)	06	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
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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	(46,130)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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													1
2	Food Purchase	(8,280)											(8,280)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(20,148)											(20,148)	6
7	Other (specify):*													7
8	TOTAL General Services	(28,428)											(28,428)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(21,385)											(21,385)	19
20	Fees, Subscriptions & Promotions	(7,924)											(7,924)	20
21	Clerical & General Office Expenses	(9,181)	40,364										31,183	21
22	Employee Benefits & Payroll Taxes		892,052										892,052	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(38,490)	932,416										893,926	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(66,918)	932,416										865,498	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(4,526)											(4,526) 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	(4,526)											(4,526) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers												39
40	Barber and Beauty Shops	(3,558)											(3,558) 40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*	(957)											(957) 43
44	TOTAL Special Cost Centers	(4,515)											(4,515) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(75,959)	932,416										856,457 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Knox County	100%	None		None		
See Supplemental for related party information						

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	IMRF-County	\$	Knox County	100.00%	\$ 535,004	\$ 535,004	1
2	V	22	Payroll Taxes - County		Knox County	100.00%	357,048	357,048	2
3	V	21	Bookkeeping & Accounting		Knox County	100.00%	40,364	40,364	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			\$			\$ 932,416	\$ * 932,416	14

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

VII. RELATED PARTIES (continued)

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

☐ YES☒ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES (continued)

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

☐

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Roland Paulsgrove	BOD						2
3	Cheryl Nache	BOD						3
4	Lyle Johnson	BOD						4
5	Greg Bacon	BOD						5
6	Paul Stewart	BOD						6
7	William Abel	BOD						7
8	Barbara Foster	BOD						8
9	Pamela Davidson	BOD						9
10	Charles Reynolds	BOD						10
11	George L. Knapp	BOD						11
12	Shawn Pittman	BOD						12
13	David Erickson	BOD						13
14	Jeff Jefferson	BOD						14
15	Ricardo D. Sandoval	BOD						15
16	Brian Friedrich	BOD						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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	County Board Members		Committee	0%	None	Various		Per Diem	\$ 1,870	25-3	1
2	County Board Members		Committee	0%	None			Mileage	379	25-3	2
3											3
4											4
5											5
6	Knox County holds committee meetings related to the nursing home.										6
7	Per-Diems and mileage are paid separately by the nursing home.										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,249		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 County Nursing Home # 0010561 Report Period Beginning: 12/01/11 Ending: 11/30/12

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 Knox County
Street Address 200 South Sherry Street
City / State / Zip Code Galesburg, IL 61401
Phone Number (309)343-3121
Fax Number (309)343-7002

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	IMRF-County	Direct Cost	169		\$ 535,004	\$	169	\$ 535,004	1
2	22	Payroll-County	Direct Cost	169		357,048		169	357,048	2
3	21	Bookkeeping & Accounting	Direct Cost	169		40,364		169	40,364	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					\$ 932,416	\$		\$ 932,416	25

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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	7	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. \$ N/A Line # N/A

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

** 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 2011 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 2012 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:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
Facility is exempt from paying real estate taxes.					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Knox County Nursing Home

COUNTY

Knox

FACILITY IDPH LICENSE NUMBER

0010561

CONTACT PERSON REGARDING THIS REPORT

Andrew B. Cutler

TELEPHONE

(847) 374-0400

FAX #:

(847) 374-0420

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. N/A	N/A	\$ N/A	\$ N/A
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

100,375

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	1,481,040	1966	\$ 156,600	1
2					2
3	TOTALS	1,481,040		\$ 156,600	3

HFS 3745 (N-4-99)

IL478-2471

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	169		1966	1966	\$ 1,842,192	\$	50	\$ 36,844	\$ 36,844	\$ 1,714,112	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1966		46,724		20	934	934	40,527	9
10	Various		1971		146,065		20			146,065	10
11	Various		1980		9,972		20			9,972	11
12	Various		1981		650		20			650	12
13	Various		1983		14,762		20			14,762	13
14	Various		1984		31,009		20			31,009	14
15	Various		1985		73,090		20			73,090	15
16	Various		1986		141,506		20			141,506	16
17	Various		1987		142,693		20			142,693	17
18	Various		1988		60,820		20			60,820	18
19	Various		1989		47,469		20			47,469	19
20	Various		1990		29,117		20	1,456	1,456	27,262	20
21	Various		1991		17,547		20			17,547	21
22	Various		1992		197,932		20			197,932	22
23	Various		1993		97,234		20	6,482	6,482	78,458	23
24	Various		1994		45,232		20			45,232	24
25	Various		1995		58,215		20			58,215	25
26	Various		1996		76,390		20			76,390	26
27	Various		1997		26,377		20			26,377	27
28	Various		1998		39,334		20	1,676	1,676	30,134	28
29	Various		1999		21,237		20	1,190	1,190	17,901	29
30	Various		2000		20,496		20	387	387	20,496	30
31	Various		2001		1,395		20	140	140	1,272	31
32	Various		2003		161,240		20	8,448	8,448	63,553	32
33	Various		2004		116,328		20	6,827	6,827	42,990	33
34	Various		2005		327,652		20	16,383	16,383	97,641	34
35	Various		2006		1,002,155		20	49,800	49,800	249,922	35
36	Various		2007		480,150		20	4,856	4,856	19,425	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 and Improvement Costs-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 Various	2008	\$ 396,911	\$	20	\$ 7,473	\$ 7,473	\$ 29,897	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	Related Building Company (Pages 12F & 12G)							67
68	Related Party Allocations (Pages 12H & 12I)							68
69	Financial Statement Depreciation		285,146			(285,146)		69
70	TOTAL (lines 4 thru 69)	\$ 5,671,894	\$ 285,146		\$ 142,896	\$ (142,250)	\$ 3,523,319	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,671,894	\$ 285,146		\$ 142,896	\$ (142,250)	\$ 3,523,319	1
2	Wood, Wall Bases, Adhesive, Primer Paint For Center Core	2009	4,062		20	120	120	480	2
3	Replace Generator	2009	63,493		20	650	650	2,600	3
4	Soffit And Fascia	2009	213,462		20	8,158	8,158	32,632	4
5	Electrical, Lighting, Cove Bases, Wood For Front Entrance	2009	3,141		20	91	91	364	5
6	Construction For Front Entrance Project	2009	77,560		20	2,247	2,247	8,988	6
7	Grease Trap Plumbing	2009	24,417		20	1,221	1,221	3,663	7
8	Plumbing Repairs - Wing 4	2010	2,985		20	149	149	447	8
9	Pipe Repair - Wing 4	2010	4,214		20	211	211	633	9
10	Replace Curbing & Sidewalks	2010	4,800		20	240	240	720	10
11	Wing 4 Renovation- Plumbing, Tiling, Piping, Plumbing	2010	9,361		20	468	468	1,404	11
12	Oxygen Room Storage- Exhaust System, Vapor Seal Lighting	2010	4,547		20	227	227	681	12
13	Basement Doors	2010	4,547		20	227	227	681	13
14	Outside Lighting	2010	4,353		20	236	236	236	14
15	Electrical Work Wing 2, 3, 4	2011	5,815		20	97	97	97	15
16	Outside Lighting	2011	5,066		20	21	21	21	16
17	Trane Rtu (Kitchen)	2011	12,980		20	595	595	595	17
18	Wing 1 Rennovation	2011	1,459,877		20	11,809	11,809	11,809	18
19	Land Improvements	2012	4,999		20	167	167	167	19
20	Smoke Dampers	2012	8,458		20	35	35	35	20
21	Door Locks & Keypads	2012	3,329		20	42	42	42	21
22	Boiler Replacement	2012	141,379		20	3,357	3,357	3,357	22
23	Door Replacement	2012	4,245		20	106	106	106	23
24	Garbage Disposer	2012	2,318		20	68	68	68	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,741,302	\$ 285,146		\$ 173,438	\$ (111,708)	\$ 3,593,145	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1		\$ 7,741,302	\$ 285,146		\$ 173,438	\$ (111,708)	\$ 3,593,145	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		\$ 7,741,302	\$ 285,146		\$ 173,438	\$ (111,708)	\$ 3,593,145	34

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

XI. OWNERSHIP COSTS (continued)
 B. Building and Improvement Costs-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	
1		\$ 7,741,302	\$ 285,146		\$ 173,438	\$ (111,708)	\$ 3,593,145	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		\$ 7,741,302	\$ 285,146		\$ 173,438	\$ (111,708)	\$ 3,593,145	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 7,741,302	\$ 285,146		\$ 173,438	\$ (111,708)	\$ 3,593,145	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	TOTAL (lines 1 thru 33)		\$ 7,741,302	\$ 285,146		\$ 173,438	\$ (111,708)	\$ 3,593,145	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information		\$	\$		\$	\$	\$	1
2	Buildings:								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)
 B. Building and Improvement Costs-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	
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

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	
1 Related Party Information		\$	\$		\$	\$	\$	1
2 Buildings:								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								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 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued		\$	\$		\$	\$	\$	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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$1,448,159	\$	\$106,921	\$106,921	10	\$839,835	71
72	Current Year Purchases	13,741		261	261	10	261	72
73	Fully Depreciated Assets	327,750				10	327,750	73
74								74
75	TOTALS	\$1,789,650	\$	\$107,182	\$107,182		\$1,167,846	75

D. Vehicle Costs. (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		Ford Escort Wagon	1993	\$10,827	\$	\$		5	\$10,827	76
77		Ford Truck	1995	17,024				5	17,024	77
78		Van	2005	43,984				5	43,984	78
79		Van	2005	34,452				5	34,452	79
80	TOTALS			\$106,287	\$	\$			\$106,287	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)	\$9,793,839	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$285,146	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$280,620	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(4,526)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,867,278	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☐ YES

☐ NO
- If NO, see instructions.

		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: \$ 1,327 Description: See attached schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(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.

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	

(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.

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IL478-2471

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 236,482	\$		\$ 236,482	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			55,213			55,213	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			270,403			270,403	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				176,745		176,745	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						32,131		32,131	13
14	TOTAL			\$		\$ 562,098	\$ 208,876		\$ 770,974	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,304,142	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,510,354		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	711,823		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,526,319	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,154,593		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	8,949,443		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(5,304,127)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,799,909	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,326,228	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 149,180	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	392,553		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	See Supplemental Schedule	733,440		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,275,173	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,275,173	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,051,055	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,326,228	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,081,326	1
2	Restatements (describe):		2
3	Audit Adjustments to (Revenue & Expense)	(360,556)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,720,770	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,330,285	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 2,330,285	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 7,051,055	24 *

* This must agree with page 17, line 47.

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	\$ 9,795,896	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,795,896	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	238,124	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 238,124	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,582	12
13	Barber and Beauty Care	3,558	13
14	Non-Patient Meals	6,698	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	46,100	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 57,938	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,617	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20,617	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	714,098	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 714,098	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,826,673	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,657,499	31
32	Health Care	4,102,333	32
33	General Administration	1,321,026	33
	B. Capital Expense		
34	Ownership	286,473	34
	C. Ancillary Expense		
35	Special Cost Centers	794,779	35
36	Provider Participation Fee	334,278	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,496,388	40
41	Income before Income Taxes (line 30 minus line 40)**	2,330,285	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,330,285	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,300,508	44
45	Private Pay - Net Inpatient Revenue	2,195,280	45
46	Medicare - Net Inpatient Revenue	1,948,127	46
47	Other-(specify) <u>Hospice</u>	214,030	47
48	Other-(specify) <u>Insurance</u>	137,951	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,795,896	49

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	2,406	2,639	\$ 87,261	\$ 33.07	1
2	Assistant Director of Nursing	1,400	1,706	53,706	31.48	2
3	Registered Nurses	15,719	17,759	439,112	24.73	3
4	Licensed Practical Nurses	39,911	44,619	861,947	19.32	4
5	CNAs & Orderlies	127,184	144,545	2,225,323	15.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,658	2,935	46,457	15.83	9
10	Activity Assistants	5,014	5,961	73,278	12.29	10
11	Social Service Workers	7,819	9,291	122,536	13.19	11
12	Dietician					12
13	Food Service Supervisor	3,186	3,855	56,061	14.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,943	33,714	356,953	10.59	15
16	Dishwashers					16
17	Maintenance Workers	4,631	5,420	105,945	19.55	17
18	Housekeepers	14,156	15,607	213,177	13.66	18
19	Laundry	6,810	7,759	71,898	9.27	19
20	Administrator	1,516	1,712	76,019	44.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,850	9,704	187,345	19.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,620	1,637	21,268	12.99	33
34	TOTAL (lines 1 - 33)	272,823	308,863	\$ 4,998,286 *	\$ 16.18	34

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	261	\$ 10,451	01-03	35
36	Medical Director	Monthly	9,312	09-03	36
37	Medical Records Consultant	Quarterly	1,404	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,561	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	104	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	806	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	263	\$ 31,638		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
			\$	Workers' Compensation Insurance		\$ 139,206	IDPH License Fee		\$ 1,990		
Kathy Kopsack	Administrator	0.00%	76,019	Unemployment Compensation Insurance		88,940	Advertising: Employee Recruitment		616		
				FICA Taxes		357,048	Health Care Worker Background Check (Indicate # of checks performed 66)		1,729		
				Employee Health Insurance		667,225	Resident Bacground Checks 94		1,007		
				Employee Meals			Pre Employment Screening		22,210		
				Illinois Municipal Retirement Fund (IMRF)*		535,004	Dues & Subscriptions		4,715		
							Marketing		7,924		
							Licenses		578		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 76,019				Less: Public Relations Expense		()		
B. Administrative - Other							Non-allowable advertising		(7,924)		
Description			Amount				Yellow page advertising		()		
			\$								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,787,423	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 32,845		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description		Line #	Amount	Description		Amount	
Davis & Campbell	Legal		\$ 11,580				\$	Out-of-State Travel		\$	
States Attorney Appellate	Legal		45								
FGMK, LLC	Accounting/Consulting		13,714								
WIPFLI	Audit		3,560					In-State Travel		2,910	
MDI Achieve	Computer Services		8,237								
Audit Adjustment	Legal		11,277								
								Seminar Expense		5,189	
See Supplemetal Schedule								Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 48,413	TOTAL			\$	(agree to Sch. V, line 24, col. 8)			
								TOTAL		\$ 8,099	

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. County Nursing Home Association - \$655

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,770 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____

(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. \$ 334,278
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,280

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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? Line 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Wipfli

(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 County Nursing Home
0010561
Other Admin. Staff Transportation
01/01/11-12/31/11

Date	G/L Acct #	Employee Name	Reference	Amount
Various		Nursing Home Committee Members	Per Diems/ Mileage	2,249.00

Related Party Allocation	
Total	<u>2,249.00</u>

Knox County Nursing Home
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1/1/11-12/31/11

[illegible]

Knox County Nursing Home
0010561
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1/1/11-12/31/11

	Special Services - Supplies (Column 6 - Other)	Amount
13A	Medical Gas/Oxygen	23,766
13B	Oxygen Supplies	8,365
13C		
13D		
13E		
13F		
13G		
13H		
13I		
13J		
		32,131

	Special Services - Outside (Column 5 - Other)	
13K		
13L		
13M		
13N		
13O		
13P		
13Q		
13R		
13S		
13T		

	Special Services - Outside (Column 5 - Other)	
13U		
13V		
13W		
13X		
13Y		
13Z		

Knox County Nursing Home
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1/1/11-12/31/11

	Other Current Assets:	Amount	Amount
09A	SP Loan to NH	711,823	
09B			
09C			
09D			
09E			
09F			
09G			
		711,823	
	Other Non-Current Assets:	Amount	Amount
23A			
23B			
23C			
23D			
23E			
23F			
23G			
	Other Current Liabilities:	Amount	Amount
36A	Due to Others	31,757	
36B	Deferred Property Tax	701,683	
36C			
36D			
36E			
36F			
36G			
		733,440	
	Other Non-Current Liabilities:	Amount	Amount
43A			
43B			
43C			
43D			
43E			
43F			
43G			

Knox County Nursing Home
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	Description	Amount
28A		-
28B	Current Property Tax	699,061
28C	Farm Income	15,037
28D		-
28E		-
28F		-
28G		-
28H		-
28I		-
28J		-
28K		-
28L		-
28M		-
28N		-
28O		-
28P		-
28Q		-
28R		-
28S		-
28T		-
		714,098

Knox County Nursing Home
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1/1/11-12/31/11

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Barber & Beauty	1,620	1,637	21,268	12.99
	1,620	1,637	21,268	12.99

C. Professional Services

Vendor/Payee	Type	Amount
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0

**Knox County Nursing Home
0010561
Seminar Expense
01/01/11-12/31/11**

Date	G/L Acct #	Payee	Topic	Job Description	City/State	Amount
9/26/2012	004-55.580.560-000	Carl Sandburg College	Food Service Sanitation	Cooks	Galesburg	218.00
10/31/2012	004-55.580.560-000	INHAA	Trade Show	DON/Asst. DON	Springfield	250.00
10/24/2012	004-55.580.560-000	Ramirez Consulting	Social Services	SS Designees	Moline	120.00
	004-55.580.560-000	MDS National Conf.	MDS	DON/MDS Coord.	St. Louis	561.00
3/1/2012	004-55.580.560-000	Alzheimers Assoc.	Alzheimers	CNA	Peoria	75.00
5/23/2012	004-55.580.560-000	Polaris	PPS Training Manual			256.00
Online	004-55.580.560-000	UND	Dietary Manager Course	Dietary Manager	OnLine	500.00
5/16/2012	004-55.580.560-000	Alzheimers Assoc.	Activity Based Alzheimers Care	Social Service		90.00
5/16/2012	004-55.580.560-000	Alzheimers Assoc.	Activity Based Alzheimers Care	Activity		90.00
6/27/2012	004-55.580.560-000	Professional Medical	Online Con't. Educatiaon	Various	OnLine	896.00
6/26/2012	004-55.580.560-000	Med-Pass	Dietary Policy and Procedure	Dietary Manager	In-House	178.00
8/9/2012	004-55.580.560-000	INHAA	Summer Conference	Administrator	Bloomington	95.00
7/10/2012	004-55.580.560-000	Great River Wound	Wound Care	Tx Nurse	Burlington	40.00
12/28/2011	004-55.580.560-000	Upstairs Consulting	Comp. Inservice	All Staff	OnLine	415.00
1/25/2012	004-55.580.560-000	Carl Sandburg College	Food Service Sanitation	Pro Man/A Cook	Galesburg	190.00
2/22/2012	004-55.580.560-000	RCS Management	Trach Care	LPN's & RN's	In-House	100.00
3/27/2012	004-55.580.560-000	Lincoln Land Community College	Basic Restorative	Restorative RN	Springfield	680.00
4/25/2012	004-55.580.560-000	Joint Commission Res.	2012 CAMLTC	Administrator	In-House	360.00
4/9/2012	004-55.580.560-000	Healthcare ENR Inst.	2012 Nursing Lae	RN Supervisor	Mundelein	75.00
Adjustments						-
Total						<u><u>5,189.00</u></u>

**Knox County Nursing Home
0010561
Travel
12/01/11-11/30/12**

Date	G/L Acct #	Employee Name	Purpose of Trip	Job Description	City/State	Amount	
10/30/2012	004-55.580.600-280	Tammy Guile	SEMINAR	DON	Springfield	166.78	
3/15/2012	004-55.5870.66-235	Kathy Kopsack	Conference	Administrator	Peoria	123.20	
3/31/2012	004-55.580.66-235	Kathy Kopsack	Meeting	Administrator	Bloomington	52.25	
	004-55.580.560-000	T. Simkins	Restorative Rehab	Restorative RN	Springfield	376.32	
6/27/2012	004-55.580.560-000	Kathy Kopsack	Conference	Administrator	Springfield	343.84	
7/25/2012	004-55.580.560-000	C. Huddleston	Seminar	Dietary Mgr.	St. Louis, MO	135.19	
8/29/2012	004-55.580.560-000	Kathy Kopsack	INHAA Conf.	Administrator	Bloomington	99.68	
11/26/2012	004-55.580.560-000	Tammy Guile	Conference	DON	Springfield	246.40	
10/24/2012	004-55.580.560-000	T.Guile/L Hobbs	MCS National Conf.	DON/MCS Coord.	St. Louis, MO	485.64	
8/29/2012	004-55.580.560-000	Jennifer Cox	Wound Clinic	Tx Nurse	Burlington	66.82	
3/27/2012	004-55.580.560-000	Guile/L. Hobbs/T. Sh	Mileage/Food	DON/MCS Coord.	St. Louis, MO	444.55	
6/27/2012	004-55.580.560-000	T. Simkins	Restorative Rehab	Restorative RN	Springfield	370.04	
				Adjustments		-	
				Total		<u>2,910.71</u>	0.00

Knox County Nursing Home
0010561
Legal Schedule
12/1/11-11/30/12

Date	Vendor	Amount
1/25/2012	States Attorney Appellate	15.00
11/26/2012	States Attorney Appellate	30.00
7/25/2012	Davis & Cambell	633.50
7/25/2012	Davis & Cambell	288.75
10/24/2012	Davis & Cambell	550.00
	Total	<u>1,517.25</u>
Total Legal		22,901.75
Non-Allowable Legal Adj. P5		<u>(21,384.50)</u>
Allowable Legal	Total	<u>1,517.25</u>