

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0020255

Facility Name: Piatt County Nursing Home

Address: 1111 N. State St., PO Box 410 Monticello 61856
Number City Zip Code

County: Piatt

Telephone Number: 217-762-2506 Fax # 217-762-2507

HFS ID Number:

Date of Initial License for Current Owners: 12/1/73

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT
☐ Charitable Corp.
☐ Trust

IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☒ State
☒ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Margel S. Peddicord, CPA Telephone Number: 217-787-8554
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/10 to 11/30/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) See Accountant's Compilation Report	(Date) _____
	(Print Name and Title) Margel S. Peddicord CPA	
	(Firm Name & Address) Margel S. Peddicord, CPA 5300 Jaeger Dr. Springfield, IL 62711	
	(Telephone) 217-787-8554	Fax # ()
	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	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Piatt County Nursing Home

0020255 Report Period Beginning: 12/01/10 Ending: 11/30/11

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	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,297	18,112	2,021	34,430	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,297	18,112	2,021	34,430	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.33%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department?
_____ (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)
Senior citizen meals, Meals for Kirby Hosp., Piatt Co. Jail meals

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 12/1/73

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 100 and days of care provided 2,021

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number	Piatt County Nursing Home	#	0020255	Report Period Beginning:	12/01/10	Ending:	11/30/11
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	447,067	62,879	12,940	522,886		522,886	(40,000)	482,886			1
2	Food Purchase		307,171		307,171		307,171	(41,375)	265,796			2
3	Housekeeping	131,339	26,441	804	158,584		158,584		158,584			3
4	Laundry	43,208	13,619	120,529	177,356		177,356		177,356			4
5	Heat and Other Utilities			79,520	79,520		79,520		79,520			5
6	Maintenance	166,100	14,543	82,874	263,517		263,517	2,046	265,563			6
7	Other (specify):*											7
8	TOTAL General Services	787,714	424,653	296,667	1,509,034		1,509,034	(79,329)	1,429,705			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	2,409,226	217,257	392,748	3,019,231		3,019,231	(1,508)	3,017,723			10
10a	Therapy		246	229,750	229,996		229,996		229,996			10a
11	Activities	131,867	5,269	3,500	140,636		140,636		140,636			11
12	Social Services	45,944	1,365	4,672	51,981		51,981		51,981			12
13	CNA Training	5,945		7,811	13,756		13,756		13,756			13
14	Program Transportation			1,023	1,023		1,023		1,023			14
15	Other (specify):* Vol. coordinator	20,469	335	674	21,478		21,478		21,478			15
16	TOTAL Health Care and Programs	2,613,451	224,472	641,378	3,479,301		3,479,301	(1,508)	3,477,793			16
	C. General Administration											
17	Administrative	74,662			74,662		74,662		74,662			17
18	Directors Fees											18
19	Professional Services			32,679	32,679		32,679		32,679			19
20	Dues, Fees, Subscriptions & Promotions			14,558	14,558		14,558		14,558			20
21	Clerical & General Office Expenses	174,086	10,742	59,223	244,051	(311)	243,740		243,740			21
22	Employee Benefits & Payroll Taxes			944,987	944,987		944,987		944,987			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,451	1,451	311	1,762		1,762			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			96,864	96,864		96,864		96,864			26
27	Other (specify):* Bad debt			13,360	13,360		13,360	(13,360)				27
28	TOTAL General Administration	248,748	10,742	1,163,122	1,422,612		1,422,612	(13,360)	1,409,252			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,649,913	659,867	2,101,167	6,410,947		6,410,947	(94,197)	6,316,750			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			176,651	176,651		176,651		176,651			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			3,088	3,088		3,088		3,088			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			179,739	179,739		179,739		179,739			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,384		83,384		83,384		83,384			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,826	53,826		53,826		53,826			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		83,384	53,826	137,210		137,210		137,210			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,649,913	743,251	2,334,732	6,727,896		6,727,896	(94,197)	6,633,699			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,360)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See attached</u>	(80,837)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (94,197)		\$	30

BHF USE ONLY							
48		49		50		51	

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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (94,197)		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	<u>Gift and Coffee Shops</u>					40
41	<u>Barber and Beauty Shops</u>					41
42	<u>Laboratory and Radiology</u>					42
43	<u>Prescription Drugs</u>					43
44						44
45	<u>Other-Attach Schedule</u>					45
46	<u>Other-Attach Schedule</u>					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

ID#0020255

Report Period Beginning:12/01/10

Ending:11/30/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non Patient Meals	\$ (41,375)	2	1
2	Non Patient Meals	(40,000)	1	2
3	Offset expense refunds, manpower, rebates	(1,508)	10	3
4	Reclissify from bldg. to maint. items under \$2,500	2,046	6	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	(80,837)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/10 Ending: 11/30/11

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	(40,000)	0	0	0	0	0	0	0	0	0	0	(40,000)	1
2	Food Purchase	(41,375)	0	0	0	0	0	0	0	0	0	0	(41,375)	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,046	0	0	0	0	0	0	0	0	0	0	2,046	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(79,329)	0	0	0	0	0	0	0	0	0	0	(79,329)	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	(1,508)	0	0	0	0	0	0	0	0	0	0	(1,508)	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	(1,508)	0	0	0	0	0	0	0	0	0	0	(1,508)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(13,360)	0	0	0	0	0	0	0	0	0	0	(13,360)	27
28	TOTAL General Administration	(13,360)	0	0	0	0	0	0	0	0	0	0	(13,360)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(94,197)	0	0	0	0	0	0	0	0	0	0	(94,197)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/10 Ending: 11/30/11

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(94,197)	0	0	0	0	0	0	0	0	0	0	(94,197)	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
NA		NA		NA		

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		NA	\$	NA		\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	Not Applicable								\$		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

SEE ACCOUNTANTS' COMPILATION REPORT

#	0020255	Report Period Beginning:	12/01/10	Ending:	11/30/11
---	---------	--------------------------	----------	---------	----------

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

Name of Related Organization NA

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	NA								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				NA			\$				\$	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	NA	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 2011 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:		2006	NA	8		
		2007		9		
		2008		10		
		2009		11		
		2010		12		
				13	FROM R. E. TAX STATEMENT FOR 2010	13
				14	PLUS APPEAL COST FROM LINE 5	14
				15	LESS REFUND FROM LINE 6	15
				16	AMOUNT TO USE FOR RATE CALCULATION\$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Piatt County Nursing Home COUNTY Piatt

FACILITY IDPH LICENSE NUMBER 0020255

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 2010 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 2010.

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

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 37,120

B. General Construction Type: Exterior Brick Frame Comb. 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).

NA

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	Nursing Home	182,592	1972	\$ 35,000	1
2					2
3	TOTALS	182,592		\$ 35,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1973	1973	\$ 800,000	\$	30	\$	\$	\$ 800,000	4
5	36		1975	1974	525,102		30			525,102	5
6	4		1989	1989	863,408	28,780	30	28,780		647,620	6
7	Bldg Proj		1993	1993	244,299	8,143	30	8,143		150,656	7
8											8
	Improvement Type**										
9	Building Improvements			1976	7,130		20			7,130	9
10	Building Improvements			1977	8,236		20			8,236	10
11	Building Improvements			1978	541		20			541	11
12	Building Improvements			1979	4,254		20			4,254	12
13	Building Improvements			1980	170,832		20			170,832	13
14	Building Improvements			1981	6,276		20			6,276	14
15	Building Improvements			1982	6,960		20			6,960	15
16	Building Improvements			1983	56,871		20			56,871	16
17	Building Improvements			1984	1,490		5			1,490	17
18	Building Improvements			1984	1,831		10			1,831	18
19	Building Improvements			1984	7,260		20			7,260	19
20	Building Improvements			1985	962		5			962	20
21	Building Improvements			1985	18,315		20			18,315	21
22	Building Improvements			1986	6,415		10			6,415	22
23	Building Improvements			1986	5,472		20			5,472	23
24	Building Improvements			1987	7,987		5			7,987	24
25	Building Improvements			1987	3,597		10			3,597	25
26	Building Improvements			1987	1,000		15			1,000	26
27	Building Improvements			1987	1,509		20			1,509	27
28	Building Improvements			1988	5,395		5			5,395	28
29	Building Improvements			1988	22,150		15			22,150	29
30	Building Improvements			1988	22,737		20			22,737	30
31	Building Improvements			1989	72,494		15			72,494	31
32	Building Improvements			1989	18,169		5			18,169	32
33	Building Improvements			1990	13,836		15			13,836	33
34	Building Improvements			1991	1,120		5			1,120	34
35	Building Improvements			1991	2,890		10			2,890	35
36	Building Improvements			1991	44,194		15			44,194	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Piatt County Nursing Home**# **0020255**

Report Period Beginning:

12/01/10

Ending:

11/30/11**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 Building Improvement	1992	\$ 5,532	\$	10	\$	\$	\$ 5,532	37
38 Building Improvement	1993	21,036		10			21,036	38
39 Building Improvement	1994	5,888		10			5,888	39
40 Building Improvement	1995	8,381		10			8,381	40
41 Bldg Imp: Admin Office & ARD Remodel; Crash Carts 50's & 60's	1996	7,582		10			7,582	41
42 Bldg Imp: New Pipes & New Roof	1997	227,748	11,388	20	11,388		165,119	42
43 Bldg Imp: New Water Heater	1998	5,377	358	15	358		4,837	43
44 Bldg Imp: Patient Rooms & Halls; Water Heater Installs	1998	4,046	202	20	202		2,730	44
45 Bldg Imp: Security Systm & Heat Pump	1999	17,009		5			17,009	45
46 Bldg Imp: Kitchen Remodel; Halcyon Roof & Remodel	1999	85,221	4,261	20	4,261		53,263	46
47 Bldg Imp: Telephone & Wiring;Handicap; Carrier Units	2000	13,585		10			13,585	47
48 Bldg Imp: Overbed Lights; Dining Room Remodel	2000	23,373	1,558	10	1,558		18,697	48
49 Bldg Imp: Resident Room & Common Area Remodeling	2001	46,868		10			46,868	49
50 Bldg Imp: Carrier Units	2001	3,080	205	15	205		2,258	50
51 Bldg Imp: Garage & Feasibilty Study	2002	4,588	459	10	459		4,360	51
52 Bldg Imp: Overbed Lights; Closet Doors; Convector	2002	21,597	1,440	15	1,440		13,680	52
53 Bldg Imp: Tile work in Shower Rooms	2002	2,267	113	20	113		1,076	53
54 Bldg Imp: Sprinkler Work	2003	9,840	394	8	394		3,347	54
55 Bldg Imp: Halcyon Kitchen; Beauty shop; admin roof; entry door	2004	13,838	1,384	10	1,384		10,380	55
56 Bldg Imp: Halcyon Awning & Convector	2004	5,108	341	15	341		2,556	56
57 Bldg Imp: Shower Repair	2004	985	49	20	49		369	57
58 Bldg Imp: Act. Office remodel; paint & Tile; Motor for Boiler	2005	676	68	10	68		441	58
59 Bldg Imp: Air Conditioning 1st & 2nd Stage Compressors	2005	12,416	828	15	828		5,381	59
60 Bldg Imp: Nurse Call System; Fire Wall Work	2006	68,545	6,855	10	6,855		37,701	60
61 Bldg Imp: Concrete Sidewalk	2006	5,695	380	15	380		2,089	61
62 Bldg Imp: Sewer Replacement & Repair	2006	7,193	288	25	288		1,583	62
63 Bldg Imp: Admin Carpet	2007	2,552	510	5	510		2,040	63
64 Bldg Imp: Dining & Kitchen Roof; Oasis Flooring	2007	8,265	1,181	7	1,181		4,724	64
65 Bldg Imp: Nook & 80s Hall Remodel;LR Furnace;water heater; ligh	2008	64,282	6,428	10	6,428		22,498	65
66 Bldg Imp: Mop Sink	2008	895	45	20	45		157	66
67 Bldg Imp: Sprinkler System	2008	3,288	132	25	132		462	67
68 Bldg Imp: Halcyon Remodel - Cove Base, Chair Rail, Cubicle Curta	2009	50,742	5,074	10	5,074		12,716	68
69 Bldg Imp: Dishroom Remodel-plumbing, flooring, paint,	2009	11,898	793	15	793		1,983	69
70 TOTAL (lines 4 thru 69)		\$ 3,722,128	\$ 81,657		\$ 81,657	\$	\$ 3,143,629	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Piatt County Nursing Home

0020255

Report Period Beginning:

12/01/10

Ending:

11/30/11

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 Totals from Page 12A, Carried Forward		\$ 3,722,128	\$ 81,657		\$ 81,657	\$	\$ 3,143,629	1
2 Bldg Imp: Attic Access between PCNH & MP	2009	528	26	20	26		65	2
3 Grnds Imp	1976	954		10			954	3
4 Grnds Imp	1977	2,298		10			2,298	4
5 Grnds Imp	1978	1,729		10			1,729	5
6 Grnds Imp	1979	6,235		10			6,235	6
7 Grnds Imp	1980	3,031		10			3,031	7
8 Grnds Imp	1981	2,803		10			2,803	8
9 Grnds Imp	1982	1,196		10			1,196	9
10 Grnds Imp	1983	1,212		12			1,212	10
11 Grnds Imp	1984	7,796		10			7,796	11
12 Grnds Imp	1986	1,077		10			1,077	12
13 Grnds Imp	1987	6,713		3			6,713	13
14 Grnds Imp	1987	1,118		10			1,118	14
15 Grnds Imp	1989	11,701		10			11,701	15
16 Grnds Imp	1990	2,682		10			2,682	16
17 Grnds Imp	1992	51,409		10			51,409	17
18 Grnds Imp	1993	4,988		10			4,988	18
19 Grnds Imp: New Sign front/rear entrance; restripe lot	1996	9,884		10			9,884	19
20 Grnds Imp: Tree Removal & Evacuation	1998	8,691						20
21 Grnds Imp: ARD Awning; Truck Turnarounds; Sidewalk	1998	6,461		10			6,461	21
22 Grnds Imp: Tile Repair	1999	765		10			765	22
23 Grnds Imp: Conrete Patio	2000	2,107		10			2,107	23
24 Grnds Imp: Landscaping	2001	1,850		5			1,850	24
25 Grnds Imp: Surfacing, Striping * Patching of Parking Lot	2003	14,884	1,861	8	1,861		15,818	25
26 GASB 34 ADJ in 2004	2004	(16,641)					(16,641)	26
27 Grnds Imp: Drive Resurfacing	2007	1,300	87	5	87		391	27
28 Grnds Imp: Fence	2008	6,460	431	15	431		1,506	28
29 Grnds Imp: Smoking Hut	2008	2,637	132	20	132		461	29
30 Grnds Imp: Fence Removal	2009	4,382	292	15	292		730	30
31 Halcyon area: floor, walls, plumbing, sinks	2010	307,152	30,715	10	30,715		46,073	31
32 Paint & wallcovering	2010	10,751	2,150	5	2,150		3,225	32
33 Automatic doors	2010	11,346	1,135	10	1,135		1,706	33
34 TOTAL (lines 1 thru 33)		\$ 4,201,627	\$ 118,486		\$ 118,486	\$	\$ 3,324,972	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	Totals from Page 12B, Carried Forward		\$ 4,201,627	\$ 118,486		\$ 118,486	\$	\$ 3,324,972	1
2	Chiller water lines	2010	25,169	2,517	10	2,517		3,775	2
3	AC Furnace 180s hall	2010	12,897	1,290	10	1,290		1,935	3
4	Electrical upgrade outlets	2010	3,921	392	10	392		588	4
5	AC unit garage	2010	4,045	809	5	809		1,214	5
6	Grounds-Storm grate & drain repair	2011	5,831	194	15	194		194	6
7	Lighting upgrade & ballasts, etc	2011	10,428	521	10	521		521	7
8	Air conditioner, rooftop, 10 ton	2011	10,094	505	10	505		505	8
9	Boiler	2011	60,063	1,502	20	1,502		1,502	9
10	Closet remodel	2011	5,787	289	10	289		289	10
11	Wiring cable throughout facility	2011	16,178	190	10	190		190	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)		\$ 4,356,040	\$ 126,695		\$ 126,695	\$	\$ 3,335,685	34

SEE ACCOUNTANTS' COMPILATION REPORT

****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	\$ 558,747	\$ 47,617	\$ 47,617	\$		\$ 378,725	71
72	Current Year Purchases	31,875	2,339	2,339			2,339	72
73	Fully Depreciated Assets	567,831					567,831	73
74								74
75	TOTALS	\$ 1,158,453	\$ 49,956	\$ 49,956	\$		\$ 948,895	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				\$	\$	\$	\$		\$	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)	\$ 5,549,493	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 176,651	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 176,651	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)	\$ 4,284,580	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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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:	1975	Storage		\$ 3,088			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 3,088			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 EndingAnnual Rent

12. /2012\$

13. /2013\$

14. /2014\$

* 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.)

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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		hrs	\$	4,949	\$ 92,258	\$	4,949	\$ 92,258	1
2	Licensed Speech and Language Development Therapist		hrs		2,455	95,916		2,455	95,916	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		4,126	41,577		4,126	41,577	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				58,576		58,576	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab</u>					24,809			24,809	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	11,530	\$ 254,560	\$ 58,576	11,530	\$ 313,136	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 197,606	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,007,473		3
4	Supply Inventory (priced at)	44,043		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	72,186		8
9	Other(specify): Funded depr.	165,997		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,487,305	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,000		13
14	Buildings, at Historical Cost	4,370,794		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,190,179		16
17	Accumulated Depreciation (book methods)	(4,284,689)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,311,284	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,798,589	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 201,061	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	215,523		30
31	Accrued Taxes Payable (excluding real estate taxes)	233,284		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	Provider Assessment	22,813		36
37	Related Entities Payable	599,849		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,272,530	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,272,530	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,526,059	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,798,589	\$	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,372,857	1
2	Restatements (describe):		2
3	Prior year adjustment by Audit Firm -- IGT funds received	522,338	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,895,195	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(369,136)	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)	\$ (369,136)	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)	\$ 2,526,059	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,152,612	1
2	Discounts and Allowances for all Levels	(1,660,410)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,492,202	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	343,636	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 343,636	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,816	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,235	13
14	Non-Patient Meals	101,719	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	73,333	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,231	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	5,843	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 198,177	23
	D. Non-Operating Revenue		
24	Contributions	1,140,959	24
25	Interest and Other Investment Income***	466	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,141,425	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Grants & Outreach revenue net of expense	183,319	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 183,319	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,358,759	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,509,034	31
32	Health Care	3,479,301	32
33	General Administration	1,422,612	33
	B. Capital Expense		
34	Ownership	179,739	34
	C. Ancillary Expense		
35	Special Cost Centers	137,210	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Rounding	(1)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,727,895	40
41	Income before Income Taxes (line 30 minus line 40)**	(369,136)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (369,136)	43

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

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

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

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

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	2,091	2,038	\$ 62,383	\$ 30.61	1
2	Assistant Director of Nursing	1,940	2,464	56,398	22.89	2
3	Registered Nurses	15,189	16,637	425,973	25.60	3
4	Licensed Practical Nurses	15,922	17,408	411,421	23.63	4
5	CNAs & Orderlies	92,925	98,251	1,424,766	14.50	5
6	CNA Trainees	462	462	5,945	12.87	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	358	358	5,992	16.74	9
10	Activity Assistants	9,777	10,888	125,875	11.56	10
11	Social Service Workers	2,711	3,279	45,944	14.01	11
12	Dietician					12
13	Food Service Supervisor	1,868	2,272	52,629	23.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,793	33,613	394,438	11.73	15
16	Dishwashers					16
17	Maintenance Workers	10,066	10,941	166,100	15.18	17
18	Housekeepers	9,705	10,694	131,339	12.28	18
19	Laundry	3,664	3,936	43,208	10.98	19
20	Administrator	1,825	2,072	74,662	36.03	20
21	Assistant Administrator					21
22	Other Administrative	8,861	10,006	174,086	17.40	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					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>Vol. Nsg sec.</u>	3,079	3,614	48,754	13.49	33
34	TOTAL (lines 1 - 33)	212,236	228,933	\$ 3,649,913 *	\$ 15.94	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 8,150	1-3	35
36	Medical Director				36
37	Medical Records Consultant		1,872	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,725	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,747		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,057	\$ 175,161	10-3	50
51	Licensed Practical Nurses	1,477	50,131	10-3	51
52	Certified Nurse Assistants/Aides	6,914	146,967	10-3	52
53	TOTAL (lines 50 - 52)	12,448	\$ 372,259		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Karla Bradley	Executive Director	0	\$ 74,662	Workers' Compensation Insurance		\$ 72,300	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance		25,488	Advertising: Employee Recruitment	3,215	
				FICA Taxes		273,656	Health Care Worker Background Check		
				Employee Health Insurance		257,360	(Indicate # of checks performed 44)	1,160	
				Employee Meals			Patient Background Checks 75	750	
				Illinois Municipal Retirement Fund (IMRF)*		303,594	LSN	5,914	
				Awards program		4,601	Employers Association	513	
				Other employee benefits		6,978	INHAA	100	
				Employee physicals		1,010	Local bus. assoc. dues	916	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)									
B. Administrative - Other									
Description			Amount				Less: Public Relations Expense	()	
			\$				Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,558	
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	
Margel S. Peddicord, CPA	Medicaid CR & consulting		\$ 5,483			\$	Out-of-State Travel	\$	
CJ Schlosser, CPAs	Medicare cost report		3,500						
May, Cocagne & King	Audit		16,500						
Pathway Health Services	Consulting		6,896				In-State Travel		
Larson Allen	Admin. Consulting		300						
	</								

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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?
If YES, give association name and amount.

Yes
LSN \$5,914 INHAA \$100
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
- (5)

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

Yes
10
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$38,064Line10
- (7)

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

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
- (9)

Are you presently operating under a sublease agreement?

YESXNO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YESNONOX
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$53,826
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No
- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$
Indicate the amount. \$
- (16)

Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
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?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No
No
\$
Yes
NA
Na

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$
- (17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
May, Cocagne & King
- (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?
Attach invoices and a summary of services for all architect and appraisal fees

NA

SEE ACCOUNTANTS' COMPILATION REPORT

**Attachment for Page 21 Section G
Piatt Co. NH
Support Schedules - Travel and Seminar
For the Year Ended November 30, 2011**

Month of Service	Name of Individuals Attending	Job Title	Dates Attended	Location	Title of Seminar	Sponsor	*Group Classification	Cost
March	Karla Bradley	Executive Director	03/23-03/25	Chicago	LSN Annual Conference	LSN		\$1,083.78
August	Rita Clarkson	Personnel Coordinator	8/4/2011	Webinar	Illinois Workers Compensation Reform 2011	LSN		\$54.50
August	Sue Craig	Personnel Director	8/4/2011	Webinar	Illinois Workers Compensation Reform 2011	LSN		\$54.50
September	Karla Bradley	Executive Director	9/22/2011	Springfield	Healthcare Reform	LSN		\$227.34
October	Karla Bradley	Executive Director	10/19/2011	Peoria	EA Strategic Directions Conference	AAIM Employer's Assoc.		\$322.76
October	Sue Craig	Personnel Director	10/12/2011	Webinar	Prepare: Disasters are More Than Headlines	Mather Lifeways Institute		\$19.33
	TOTAL							\$1,762.21

Group Classification: (1) Out-of-State Travel, (2) In-State Travel, (3) Seminar Expense, (4) Education and Seminars, (5) Administrative Seminars, (6) Entertainment Expense.