

		FOR BHF USE					

LL1

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>0004234</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>SCOTT COUNTY NURSING CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/11</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>650 N. MAIN ST, P.O. BOX 110</u> <u>WINCHESTER</u> <u>62694</u>																									
Number City Zip Code																									
County: <u>SCOTT</u>																									
Telephone Number: <u>217-742-3101</u> Fax # <u>217-742-5603</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) <u>DEBBIE O'DELL</u></td></tr><tr><td>(Title) <u>ADMINISTRATOR</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>JOHN L. EYTH</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>ZUMBAHLEN, EYTH, SURRETT, FOOTE & FLYNN, LTI</u> <u>1395 LINCOLN AVE, JACKSONVILLE, IL 62650</u></td></tr><tr><td>(Telephone) <u>217-245-5121</u> Fax # <u>217-243-3356</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>DEBBIE O'DELL</u>	(Title) <u>ADMINISTRATOR</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>JOHN L. EYTH</u> <u>PARTNER</u>	(Firm Name & Address) <u>ZUMBAHLEN, EYTH, SURRETT, FOOTE & FLYNN, LTI</u> <u>1395 LINCOLN AVE, JACKSONVILLE, IL 62650</u>	(Telephone) <u>217-245-5121</u> Fax # <u>217-243-3356</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>DEBBIE O'DELL</u>																								
	(Title) <u>ADMINISTRATOR</u>																								
	(Signed) _____																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) <u>JOHN L. EYTH</u> <u>PARTNER</u>																								
	(Firm Name & Address) <u>ZUMBAHLEN, EYTH, SURRETT, FOOTE & FLYNN, LTI</u> <u>1395 LINCOLN AVE, JACKSONVILLE, IL 62650</u>																								
	(Telephone) <u>217-245-5121</u> Fax # <u>217-243-3356</u>																								
Date of Initial License for Current Owners: <u>4/19/1971</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☒ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☒ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
☐ Trust	☐ Partnership	☒ County																							
IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>KATHY PASCAL</u> Telephone Number: <u>217-742-3101</u>																									
Email Address: _____																									

Facility Name & ID Number SCOTT COUNTY NURSING CENTER# 0004234 Report Period Beginning: 12/1/11 Ending: 11/30/12

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>49</u>	Skilled (SNF)	<u>49</u>	<u>17,885</u>	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	<u>49</u>	TOTALS	<u>49</u>	<u>17,885</u>	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			<u>1,538</u>	<u>1,538</u>	8
9	SNF/PED					9
10	ICF	<u>7,425</u>	<u>5,400</u>		<u>12,825</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,425</u>	<u>5,400</u>	<u>1,538</u>	<u>14,363</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 80.31%

D. How many bed-hold days during this year were paid by the Department?

0 (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)DAY CARE

F. Does the facility maintain a daily midnight census?

YESG. 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 4/19/1971

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 49 and days of care provided Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☐ MODIFIED
CASH* ☒ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: N/A Fiscal Year: 11/30

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

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	135,886	7,136	4,508	147,530		147,530		147,530			1
2	Food Purchase		83,902		83,902		83,902	(104)	83,798			2
3	Housekeeping	59,105	8,104		67,209		67,209		67,209			3
4	Laundry	18,082	3,240		21,322		21,322		21,322			4
5	Heat and Other Utilities			63,346	63,346		63,346		63,346			5
6	Maintenance	25,696	3,968	58,914	88,578		88,578		88,578			6
7	Other (specify):*											7
8	TOTAL General Services	238,769	106,350	126,768	471,887		471,887	(104)	471,783			8
	B. Health Care and Programs											
9	Medical Director			9,450	9,450		9,450		9,450			9
10	Nursing and Medical Records	971,312	179,037	186,475	1,336,824		1,336,824	(427)	1,336,397			10
10a	Therapy											10a
11	Activities	51,552	2,377	250	54,179		54,179		54,179			11
12	Social Services	20,609		389	20,998		20,998		20,998			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,043,473	181,414	196,564	1,421,451		1,421,451	(427)	1,421,024			16
	C. General Administration											
17	Administrative	56,795	15,920		72,715		72,715		72,715			17
18	Directors Fees											18
19	Professional Services			16,457	16,457		16,457		16,457			19
20	Dues, Fees, Subscriptions & Promotions			5,269	5,269		5,269		5,269			20
21	Clerical & General Office Expenses	29,754			29,754		29,754	6,429	36,183			21
22	Employee Benefits & Payroll Taxes			103,585	103,585		103,585	184,427	288,012			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,424	7,424		7,424		7,424			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			200	200		200	8,594	8,794			26
27	Other (specify):*			15,660	15,660		15,660	(15,660)				27
28	TOTAL General Administration	86,549	15,920	148,595	251,064		251,064	183,790	434,854			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,368,791	303,684	471,927	2,144,402		2,144,402	183,259	2,327,661			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			47,791	47,791		47,791		47,791			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			256	256		256	(256)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			48,047	48,047		48,047	(256)	47,791			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			112,562	112,562		112,562		112,562			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			112,562	112,562		112,562		112,562			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,368,791	303,684	632,536	2,305,011		2,305,011	183,003	2,488,014			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(104)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(427)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(256)	32		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	(15,660)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (16,447)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	199,450		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 199,450		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 183,003		37

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

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

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

STATE OF ILLINOIS
SCOTT COUNTY NURSING CENTER

Report Period Beginning: ID# 0004234
Ending: 12/1/11
11/30/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/1/11 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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(104)	0	0	0	0	0	0	0	0	0	0	(104)	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(104)	0	0	0	0	0	0	0	0	0	0	(104)	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	(427)	0	0	0	0	0	0	0	0	0	0	(427)	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	(427)	0	0	0	0	0	0	0	0	0	0	(427)	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	6,429	0	0	0	0	0	0	0	0	0	6,429	21
22	Employee Benefits & Payroll Taxes	0	184,427	0	0	0	0	0	0	0	0	0	184,427	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	8,594	0	0	0	0	0	0	0	0	0	8,594	26
27	Other (specify):*	(15,660)	0	0	0	0	0	0	0	0	0	0	(15,660)	27
28	TOTAL General Administration	(15,660)	199,450	0	0	0	0	0	0	0	0	0	183,790	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,191)	199,450	0	0	0	0	0	0	0	0	0	183,259	29

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	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	(256)	0	0	0	0	0	0	0	0	0	0	(256)	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	(256)	0	0	0	0	0	0	0	0	0	0	(256)	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)	(16,447)	199,450	0	0	0	0	0	0	0	0	0	183,003	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

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			\$			\$		1
2	V	21	CLERICAL		SCOTT COUNTY	100.00%	6,429	6,429	2
3	V	22	IMRF		SCOTT COUNTY	100.00%	132,230	132,230	3
4	V	22	WORKMAN'S COMPENSATION		SCOTT COUNTY	100.00%	39,343	39,343	4
5	V	22	UNEMPLOYMENT		SCOTT COUNTY	100.00%	12,854	12,854	5
6	V	26	INSURANCE		SCOTT COUNTY	100.00%	8,594	8,594	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 199,450	\$ * 199,450	14

* 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								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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/1/11 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 SCOTT COUNTY
Street Address COURTHOUSE
City / State / Zip Code WINCHESTER, IL 62694
Phone Number (217-742-3368
Fax Number (217-742-5853

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	BOOKKEEPING	HOURS	2,080	2	\$ 32,144	\$ 26,309	416	\$ 6,429	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					\$ 32,144	\$ 26,309		\$ 6,429	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. \$ _____ Line # _____

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 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	
				13	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	SCOTT COUNTY NURSING CENTER	COUNTY	SCOTT
---------------	-----------------------------	--------	-------

FACILITY IDPH LICENSE NUMBER 0004234

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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 provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,909

B. General Construction Type: Exterior BRICK

Frame CONCRETE

Number of Stories ONE

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SITE	108,909	1970	\$ 1,567	1
2					2
3	TOTALS	108,909		\$ 1,567	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	49		1971	1971	\$ 174,649	\$	40	\$	\$	174,649	4
5			1971	1971	1,500		20			1,500	5
6			1974	1974	20,633		37			20,633	6
7			1974	1974	16,129		VAR			16,129	7
8											8
	Improvement Type**										
9	ENERGY CONTROL			1983	18,678		20			18,678	9
10	WINDOW REMODELING			1986	1,980		20			1,980	10
11	WATER HEATER			1988	5,453		16			5,453	11
12	ELECTRICAL			1989	13,795		20			13,795	12
13	PARKING LOT			1989	3,480		16			3,480	13
14	DOOR - EAST SIDE			1989	1,565		20			1,565	14
15	SPRINKLER SYSTEM			1989	3,150	126	25	126		3,024	15
16	LIGHTS			1990	3,561		10			3,561	16
17	ROOF			1991	57,367		10			57,367	17
18	GARAGE			1991	9,291		20			9,291	18
19	FOLDING DOOR			1991	1,751		10			1,751	19
20	ELECTRICAL			1992	3,018		10			3,018	20
21	COUNTER TOP			1992	1,920		6			1,920	21
22	BUILDING ADDITION			1993	142,244	4,741	30	4,741		92,450	22
23	PARKING LOT			1993	10,135		16			10,135	23
24	LAUNDRY			1995	22,174	739	30	739		12,933	24
25	GENERATOR FUEL TANK			1998	4,712	314	15	314		4,553	25
26	ELECTRICAL			1998	1,594		10			1,594	26
27	DINING ROOM			2000	274,460	9,149	30	9,149		114,362	27
28	PATIENT ROOM UPDATE - TILING & FURNITURE			2000	32,985		10			32,985	28
29	FULLY DEPRECIATED FIXED EQUIPMENT			1971	198,138		VAR			198,138	29
30	PATIENT ROOM UPDATE - TILING & FURNITURE			2001	24,779		10			24,779	30
31	SPRINKLER SYSTEM			2001	9,800	392	25	392		4,508	31
32	KITCHEN UPDATE - COOLER,VENT			2002	37,053	1,855	10	1,855		37,053	32
33	GENERATOR			2005	13,787	1,379	10	1,379		10,342	33
34	FIRE ALARM UPDATE			2005	28,315	1,416	20	1,416		10,620	34
35	PATIENT ROOM UPDATE - HANDICAP ACCESSIBLE			2010	3,389	338	10	338		845	35
36	FRIENDSHIP GARDEN			2011	53,775	2,689	20	2,689		3,957	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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$1,195,260	\$23,138		\$23,138	\$	\$897,048	70

**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	\$ 144,207	\$ 13,604	\$ 13,604	\$	10	\$ 92,767	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 144,207	\$ 13,604	\$ 13,604	\$		\$ 92,767	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	PROGRAM TRANS	VAN CHEV 2009	2009	\$ 55,243	\$ 11,049	\$ 11,049	\$	5	\$ 38,671	76
77										77
78										78
79										79
80	TOTALS			\$ 55,243	\$ 11,049	\$ 11,049	\$		\$ 38,671	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 1,396,277	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 47,791	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,791	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)	\$ 1,028,486	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:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

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

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

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

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

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

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

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

		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	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

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	\$ 852,088	\$ 852,088	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			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):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 852,088	\$ 852,088	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,567	1,567	13
14	Buildings, at Historical Cost	1,195,260	1,195,260	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	199,450	199,450	16
17	Accumulated Depreciation (book methods)	(1,028,486)	(1,028,486)	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)	\$ 367,791	\$ 367,791	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,219,879	\$ 1,219,879	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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	DUE TO INSURANCE FUND	100,546	100,546	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 100,546	\$ 100,546	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,655	2,655	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)	\$ 2,655	\$ 2,655	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 103,201	\$ 103,201	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,116,678	\$ 1,116,678	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,219,879	\$ 1,219,879	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 850,550	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 850,550	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	266,128	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)	\$ 266,128	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)	\$ 1,116,678	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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,559,138	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,559,138	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	104	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	427	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 531	23
	D. Non-Operating Revenue		
24	Contributions	5,622	24
25	Interest and Other Investment Income***	5,848	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,470	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,571,139	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	471,887	31
32	Health Care	1,421,451	32
33	General Administration	251,064	33
	B. Capital Expense		
34	Ownership	48,047	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	112,562	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,305,011	40
41	Income before Income Taxes (line 30 minus line 40)**	266,128	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 266,128	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 923,651	44
45	Private Pay - Net Inpatient Revenue	803,166	45
46	Medicare - Net Inpatient Revenue	528,941	46
47	Other-(specify) HOSPICE	5,109	47
48	Other-(specify) SOCIAL SECURITY	298,271	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,559,138	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	1,878	2,052	\$ 49,016	\$ 23.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,745	5,329	113,389	21.28	3
4	Licensed Practical Nurses	14,974	16,959	304,977	17.98	4
5	CNAs & Orderlies	34,811	39,211	388,763	9.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,478	5,201	50,819	9.77	8
9	Activity Director	1,823	2,052	25,876	12.61	9
10	Activity Assistants	1,785	2,081	18,653	8.96	10
11	Social Service Workers	1,411	1,704	20,107	11.80	11
12	Dietician					12
13	Food Service Supervisor	1,783	2,064	23,740	11.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,222	11,785	111,649	9.47	15
16	Dishwashers					16
17	Maintenance Workers	1,853	2,080	25,696	12.35	17
18	Housekeepers	5,823	6,496	58,682	9.03	18
19	Laundry	1,550	1,752	18,583	10.61	19
20	Administrator	1,803	2,280	56,795	24.91	20
21	Assistant Administrator	847	855	7,322	8.56	21
22	Other Administrative					22
23	Office Manager	1,883	2,052	29,754	14.50	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	1,823	2,065	23,314	11.29	31
32	Other Health Care(specify)					32
33	Other(specify)	1,732	2,052	41,656	20.30	33
34	TOTAL (lines 1 - 33)	95,224	108,070	\$ 1,368,791 *	\$ 12.67	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	96	\$ 4,320		35
36	Medical Director	12	9,450		36
37	Medical Records Consultant	16	100		37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,744		39
40	Physical Therapy Consultant	1,007	84,365		40
41	Occupational Therapy Consultant	959	84,329		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	35	2,850		43
44	Activity Consultant	12	828		44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,233	\$ 188,986		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-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													
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?

NO
- (2) Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount.

ILLINOIS HEALTHCARE ASSOCIATION
- (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?

N/A
- (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.

\$ 22,772

Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

N/A
- (9) Are you presently operating under a sublease agreement?

YES

X

NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 112,562

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?

N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 0

Has any meal income been offset against related costs?

YES

Indicate the amount.

\$ 104
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100

d. Have vehicle usage logs been maintained?

YES

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm?

YES

Firm Name:

ZUMBAHLEN, EYTH, SURRATT, FOOTE & FLYNN, LTD.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.