

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0004234

Facility Name: Scott County Nursing Center

Address: 650 N Main St Box110 Winchester 62694

County: Scott

Telephone Number: (217) 742-3101 Fax # (217) 742-5603

HFS ID Number:

Date of Initial License for Current Owners: 04/19/1971

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

X

GOVERNMENTAL

State

X

County

Other

In the event there are further questions about this report, please contact:

Name: Lindey Hays Telephone Number: (217) 742-3101

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 12/01/2024 to 11/30/2025 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)

(Type or Print Name) Lindey Hays

(Title) Administrator

Paid Preparer

(Print Name and Title) Suzanne Steckel Partner

(Firm Name & Address) Zumbahlen, Eyth, Surratt, Foote & Flynn, Ltd. 1395 Lincoln Ave, Jacksonville, IL 62650

(Telephone) (217) 245-5121 Fax # (217) 243-3356

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Scott County Nursing Center # 0004234 Report Period Beginning: 12/01/2024 Ending: 11/30/2025

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 <u>N/A</u>					
	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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						2,155		2,155	8
9	SNF/PED									9
10	ICF	1,798	3,726			7,349			12,873	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,798	3,726			7,349	2,155		15,028	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 84.03%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

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

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 04/19/1971

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 certified beds.
number of certified beds 49

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.

Facility Name & ID Number Scott County Nursing Center # 0004234 Report Period Beginning: 12/01/2024 Ending: 11/30/2025

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	230,726	10,496	4,732	245,954		245,954		245,954			1
2	Food Purchase		159,152		159,152		159,152		159,152			2
3	Housekeeping	124,162	7,152		131,314		131,314		131,314			3
4	Laundry	60,569	1,496		62,065		62,065		62,065			4
5	Heat and Other Utilities			121,463	121,463		121,463		121,463			5
6	Maintenance	43,348	8,614	37,381	89,343		89,343		89,343			6
7	Other (specify):*											7
8	TOTAL General Services	458,805	186,910	163,576	809,291		809,291		809,291			8
	B. Health Care and Programs											
9	Medical Director			9,903	9,903		9,903		9,903			9
10	Nursing and Medical Records	1,749,620	198,938	52,620	2,001,178		2,001,178		2,001,178			10
10a	Therapy											10a
11	Activities	59,425	6,649	549	66,623		66,623		66,623			11
12	Social Services	41,145			41,145		41,145		41,145			12
13	CNA Training											13
14	Program Transportation		3,283	16,757	20,040		20,040		20,040			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,850,190	208,870	79,829	2,138,889		2,138,889		2,138,889			16
	C. General Administration											
17	Administrative	94,823			94,823		94,823		94,823			17
18	Directors Fees											18
19	Professional Services			19,622	19,622		19,622		19,622			19
20	Dues, Fees, Subscriptions & Promotions			8,064	8,064		8,064		8,064			20
21	Clerical & General Office Expenses	95,931	15,391		111,322		111,322	9,036	120,358			21
22	Employee Benefits & Payroll Taxes			190,421	190,421		190,421	245,468	435,889			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,111	2,111		2,111		2,111			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			200	200		200	18,152	18,352			26
27	Other (specify):* Staff Appreciation			4,862	4,862		4,862		4,862			27
28	TOTAL General Administration	190,754	15,391	225,280	431,425		431,425	272,656	704,081			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,499,749	411,171	468,685	3,379,605		3,379,605	272,656	3,652,261			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			60,559	60,559		60,559		60,559			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(1,572)	(1,572)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			60,559	60,559		60,559	(1,572)	58,987			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			284,342	284,342		284,342		284,342			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,831	82,831		82,831		82,831			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			367,173	367,173		367,173		367,173			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,499,749	411,171	896,417	3,807,337		3,807,337	271,084	4,078,421			45

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

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	(1,572)	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				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)	\$ (1,572)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	272,656		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 272,656		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 271,084		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

11/30/2025

[illegible]

Summary B

11/30/2025

[illegible]

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	21	Clerical	\$	Scott County	100.00%	\$ 9,036	\$ 9,036	1
2	V	22	IMRF		Scott County	100.00%	70,838	70,838	2
3	V	22	Workmen's Compensation		Scott County	100.00%	39,329	39,329	3
4	V	22	Unemployment		Scott County	100.00%	11,701	11,701	4
5	V	26	General Insurance		Scott County	100.00%	18,152	18,152	5
6	V	22	Health Insurance		Scott County	100.00%	123,600	123,600	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 272,656	\$ * 272,656	14

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

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

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

Ownership Listing-1

0004234

N/A

N/A

Management
Co./Home Offi

Ownership

Ownership Percentage

1	Scott County, Illinois (Government)				100.00000	100.00000	100.00000	1
2								2
3								3
4								4
5								5
6								6
7								7
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74								74
75								75

VII. RELATED PARTIES

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

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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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: 12/01/2024 Ending: 1/30/2025

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, Illinois
Street Address Scott County Courthouse
City / State / Zip Code Winchester, IL 62694
Phone Number (217) 742-3368
Fax Number (217) 742-5853

	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	21	Bookkeeping	Hours	2,080	2	\$ 45,179	\$ 40,003	416	\$ 9,036	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					\$ 45,179	\$ 40,003		\$ 9,036	25

Facility Name & ID Number Scott County Nursing Center # 0004234 Report Period Beginning: 12/01/2024 Ending: 1/30/2025

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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.

2024 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 2024 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 2024.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u> </u>	<u> </u>	\$ <u> </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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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: 18,909 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 1

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

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

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

F. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. 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	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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	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		Various			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		25			3,150	15
16	Lights		1990		3,561		10			3,561	16
17	Garage		1991		9,291		20			9,291	17
18	Folding Door		1991		1,751		10			1,751	18
19	Electrical		1992		3,018		10			3,018	19
20	Counter Top		1992		1,920		6			1,920	20
21	Building Addition		1993		142,244		30			142,244	21
22	Parking Lot		1993		10,135		16			10,135	22
23	Laundry		1995		22,174	373	30	373		22,174	23
24	Generator Fuel Tank		1998		4,712		15			4,712	24
25	Electrical		1998		1,594		10			1,594	25
26	Dining Room		2000		274,460	9,149	30	9,149		233,299	26
27	Patient Room Update - Tiling & Furniture		2000		32,985		10			32,985	27
28	Fully Depreciated Fixed Equipment		1971		198,138		Various			198,138	28
29	Patient Room Update - Tiling & Furniture		2001		24,779		10			24,779	29
30	Sprinkler System		2001		9,800	392	25	392		9,604	30
31	Kitchen Update - Cooler, Vent		2002		37,053		10			37,053	31
32	Generator Fuel Tank		2005		13,787		10			13,787	32
33	Fire Alarm Update		2005		28,315	703	20	703		28,315	33
34	Patient Room Update - Handicap Accessible		2010		3,389		10			3,389	34
35	Friendship Garden		2011		53,775	2,689	20	2,689		38,914	35
36	Fire Sprinkler System		2013		29,778	1,191	25	1,191		15,483	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

XL 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	Nurses Station Remodel	2014	\$ 3,151	\$	10	\$	\$	\$ 3,151	37
38	3 Heating & Air Units	2014	2,145	134	16	134		1,541	38
39	Roofing Project	2014	486,753		10			486,753	39
40	Oxygen Shed	2014	3,340		10			3,340	40
41	Finish Roofing Project	2015	125,966	6,295	10	6,295		125,966	41
42	Whirlpool Tub	2015	11,639	581	10	581		11,639	42
43	Security System	2016	7,979	798	10	798		7,847	43
44	Generator	2016	157,621	10,508	15	10,508		99,826	44
45	Parking Lot	2025	32,879	548	15	548		548	45
46	HVAC Repairs	2025	12,496	347	15	347		347	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)		\$ 2,011,640	\$ 33,708		\$ 33,708	\$	\$ 1,838,116	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	\$ 119,370	\$ 11,636	\$ 11,636	\$	10	\$ 83,664	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 119,370	\$ 11,636	\$ 11,636	\$		\$ 83,664	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 Transport	2024 Dodge Bus	2025	\$ 82,991	\$ 15,215	\$ 15,215	\$	5	\$ 15,215	76
77										77
78										78
79										79
80	TOTALS			\$ 82,991	\$ 15,215	\$ 15,215	\$		\$ 15,215	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)	\$ 2,215,568	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 60,559	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 60,559	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)	\$ 1,936,995	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? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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
		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.

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	Line 39, Col 3	hrs	\$	1,635	\$ 142,491	\$	1,635	\$ 142,491	1
2	Licensed Speech and Language Development Therapist	Line 39, Col 3	hrs		231	37,497		231	37,497	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 39, Col 3	hrs		615	104,354		615	104,354	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			\$	2,481	\$ 284,342	\$	2,481	\$ 284,342	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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 134,268	\$ 134,268	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)	\$ 134,268	\$ 134,268	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	2,011,640	2,011,640	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	202,361	202,361	16
17	Accumulated Depreciation (book methods)	(1,936,995)	(1,936,995)	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)	\$ 278,573	\$ 278,573	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 412,841	\$ 412,841	25

		1	2	
		Operating	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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$	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)	\$	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 412,841	\$ 412,841	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 412,841	\$ 412,841	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 244,397	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 244,397	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(160,394)	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) <u>Capital Contributions</u>	16,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (144,394)	17
	B. Transfers (Itemize):		
18	<u>Permanent Transfers from Scott County General Fund</u>	312,838	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 312,838	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 412,841	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Scott County Nursing Center

0004234

Report Period Beginning: 12/01/2024

Ending: 11/30/2025

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,496,878	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,496,878	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	4,118	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,118	23
	D. Non-Operating Revenue		
24	Contributions	18,329	24
25	Interest and Other Investment Income***	1,572	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,901	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Property Taxes	126,046	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 126,046	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,646,943	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	809,291	31
32	Health Care	2,138,889	32
33	General Administration	431,425	33
	B. Capital Expense		
34	Ownership	60,559	34
	C. Ancillary Expense		
35	Special Cost Centers	284,342	35
36	Provider Participation Fee	82,831	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,807,337	40
41	Income before Income Taxes (line 30 minus line 40)**	(160,394)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (160,394)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 313,407.96	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	365,186.06	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,465,737.76	48
49	Medicare Part A	1,128,967.33	49
50	Other-(specify) Social Security	178,963.76	50
51	Other-(specify) Hospice	17,535.67	51
52	Other-(specify) Subcontractor Income	27,079.00	52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,496,878	56

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	1,688	1,943	\$ 85,597	\$ 44.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,947	6,552	265,732	40.56	3
4	Licensed Practical Nurses	15,481	17,449	535,774	30.71	4
5	CNAs & Orderlies	33,485	36,450	761,560	20.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,960	2,144	48,868	22.79	8
9	Activity Director	1,789	2,045	41,478	20.28	9
10	Activity Assistants	974	982	17,947	18.28	10
11	Social Service Workers	1,507	1,290	41,145	31.90	11
12	Dietician					12
13	Food Service Supervisor	1,935	2,155	41,660	19.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,948	12,162	189,066	15.55	15
16	Dishwashers					16
17	Maintenance Workers	1,899	2,164	43,348	20.03	17
18	Housekeepers	7,178	8,080	124,162	15.37	18
19	Laundry	2,772	3,124	60,569	19.39	19
20	Administrator	1,989	2,164	94,823	43.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,055	2,407	54,203	22.52	23
24	Clerical	1,657	1,962	41,728	21.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,805	2,504	52,089	20.80	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	95,069	105,577	\$ 2,499,749 *	\$ 23.68	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	64	\$ 4,732	Line 1 Col 3	35
36	Medical Director	20	9,903	Line 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	132	7,958	Line 10 Col 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	8	549	Line 11 Col 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	224	\$ 23,142		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



2211 York Road, Suite 500 Oak Brook, IL 60521-2337 1-800-726-7571

www.imrf.org

Final Notice of Illinois Municipal Retirement Fund Contribution Rate for Calendar Year 2025

Date November 2024

Employer Name Scott County

Employer No. 03083

The employer rate below is based on a 15 year amortization period for most employers. Overfunded employers will receive a letter outlining options available to accelerate the amortization of their overfunding (which reduces rate) if they so choose.

Your IMRF contribution rates on all earnings paid to IMRF members and employer rates in the 2025 calendar year are as follows:

	IMRF Contributions		
	REGULAR	SLEP	ECO
Member Contributions (tax-deferred)	4.50 %	7.50 %	7.50 %
Employer Contributions			
-Retirement Rate			
Normal Cost	4.50 %	9.87 %	13.05 %
Calculated Funding Adjustment	(2.24%)	14.31 %	0.00 %
Net Retirement Rate	2.32 %	24.18 %	13.05 %
-Other Program Benefits			
Disability	0.04 %	0.04 %	0.04 %
Death	0.12 %	0.12 %	0.13 %
Supplemental Benefit Payment	0.62 %	0.62 %	0.62 %
TOTAL EMPLOYER RATE	3.10 %	24.90 %	13.84 %

You can view employer contribution rates in your Employer Access account. Employer rates for 2025 are final after the November 2024 IMRF Board of Trustees meeting. If you have any questions about employer rates, please call the IMRF Employer Contact Center at 1-800-726-7971.



Final Notice of Illinois Municipal Retirement Fund Contribution Rate for Calendar Year 2024

Date: November 2023

Employer name: SCOTT COUNTY

Employer No: 93063

The contribution rates on earnings paid by your participating governmental unit to IMRF members are shown below. The Illinois Pension Code provides that the employer is responsible for remitting both employer and member contributions to IMRF, along with the related deposit report according to prescribed due dates.

IMRF contributions must be paid on the earnings of all employees working in participating positions. Your employer contribution rate on member earnings is based upon actuarial costs for retirement, supplemental retirement, death, and disability benefits. The actuarial formula is specified in the Illinois Pension Code. Member contributions are specified in the Illinois Pension Code and help to meet the cost of future retirement benefits.

Participating governmental units with taxing powers are authorized by the Illinois Pension Code to levy a special IMRF tax for payment of employer IMRF contributions. However, this levy may be used only for employer payments. It may not be used for payment of IMRF member contributions. These must be paid out of the same fund from which the employee IMRF earnings are paid. Interest charges are assessed on any late payments. Refer to Section 4 of the IMRF Manual for Authorized Agents for interest charge procedures. If you have any questions, please contact the IMRF Employer Account Analyst at 1-800-ASK-IMRF.

Brian Collins, Executive Director

	IMRF Contributions		
	Regular	SLEP	ECO
Member Contributions (tax deferred)	4.50%	7.50%	7.50%
Employer Contributions			
• Retirement Rate			
Normal Cost	4.90%	10.35%	12.81%
Funding Adjustment (Covered under)	< 2.76%	< 2.75%	0.00%
Net Retirement Rate	2.14%	7.60%	12.81%
• Other Program Benefits			
Death	0.17%	0.16%	0.18%
Disability	0.08%	0.08%	0.08%
Supplemental Benefit Payment	0.62%	0.62%	0.62%
Early Retirement Incentive	0.00%	0.00%	0.00%
• TOTAL EMPLOYER RATE	3.01%	8.46%	13.69%

SCOTT COUNTY
MARK J. FORD, TREASURER
55 E. MARKET ST. STE 4
SCOTT COUNTY COURTHOUSE
WINCHESTER, IL 62694-1227

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 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. \$ _____
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Zumbahlen, Eyth, Surratt, Foote & Flynn, Ltd.
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.