

		FOR BHF USE				

LL 1

**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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

<p><b>I. IDPH Facility ID Number:</b> <u>0020255</u></p> <p><b>Facility Name:</b> <u>PIATT COUNTY NURSING HOME</u></p> <p><b>Address:</b> <u>1111 N STATE ST, PO BOX 410</u> <u>MONTICELLO</u> <u>61856</u>          Number City Zip Code</p> <p><b>County:</b> <u>PIATT</u></p> <p><b>Telephone Number:</b> <u>217 762 2506</u> Fax # <u>217 762 6325</u></p> <p><b>HFS ID Number:</b> <u>37-6001816W</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>12-01-1973</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>EMILY CHEEK</u> <b>Telephone Number:</b> <u>217 762 6305</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12-01-05</u> to <u>11-30-06</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>KARLA BRADLEY</u></td> </tr> <tr> <td></td> <td>(Title) <u>EXECUTIVE DIRECTOR</u></td> </tr> <tr> <td></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) (____) _____ Fax # (____) _____</td> </tr> </table> <p align="center"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630       </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) <u>KARLA BRADLEY</u>		(Title) <u>EXECUTIVE DIRECTOR</u>		(Signed) _____ (Date) _____	<b>Paid Preparer</b>	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (____) _____ Fax # (____) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL																																					
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<b>Paid Preparer</b>	(Print Name and Title) _____																																						
	(Firm Name & Address) _____																																						
	(Telephone) (____) _____ Fax # (____) _____																																						

Facility Name & ID Number PIATT COUNTY NURSING HOME

# 0020255 Report Period Beginning: 12-01-05 Ending: 11-30-06

**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF	580	690		1,270	8
9	SNF/PED					9
10	ICF	18,795	14,471		33,266	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,375	15,161		34,536	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.62%

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)

SENIOR CITIZEN MEALS, MEALS TO PATIENTS @ KIRBY HOSPITAL, PIATT COUN

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 12/01/1793

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 \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: N/A Fiscal Year: \_\_\_\_\_

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

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

PIATT COUNTY NURSING HOME

# 0020255

Report Period Beginning:

12-01-05

Ending:

11-30-06

## 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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	371,422	31,298	11,796	414,516	1,636	416,152	(147,719)	268,433		1
2	Food Purchase		250,059		250,059		250,059	(75,472)	174,587		2
3	Housekeeping	103,477	15,715	25	119,217	310	119,527		119,527		3
4	Laundry	29,828	6,163	86,390	122,381		122,381		122,381		4
5	Heat and Other Utilities			103,452	103,452		103,452		103,452		5
6	Maintenance	130,723	13,726	30,089	174,538	730	175,268		175,268		6
7	Other (specify):*	8,205	137	998	9,340		9,340	(130)	9,210		7
8	<b>TOTAL General Services</b>	<b>643,655</b>	<b>317,098</b>	<b>232,750</b>	<b>1,193,503</b>	<b>2,676</b>	<b>1,196,179</b>	<b>(223,321)</b>	<b>972,858</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,000	1,000		1,000		1,000		9
10	Nursing and Medical Records	1,885,904	183,844	564,521	2,634,269	10,809	2,645,078		2,645,078		10
10a	Therapy		2	78,940	78,942		78,942		78,942		10a
11	Activities	115,052	2,018	1,060	118,130	329	118,459		118,459		11
12	Social Services	37,373	659	2,607	40,639	1,197	41,836		41,836		12
13	CNA Training	5,393	20	1,047	6,460		6,460	(907)	5,553		13
14	Program Transportation			548	548		548		548		14
15	Other (specify):*	17,604	420	31	18,055	4	18,059	(264)	17,795		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,061,326</b>	<b>186,963</b>	<b>649,754</b>	<b>2,898,043</b>	<b>12,339</b>	<b>2,910,382</b>	<b>(1,170)</b>	<b>2,909,212</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	61,923			61,923		61,923		61,923		17
18	Directors Fees							5,696	5,696		18
19	Professional Services			16,301	16,301		16,301		16,301		19
20	Dues, Fees, Subscriptions & Promotions			26,217	26,217		26,217	(10,277)	15,940		20
21	Clerical & General Office Expenses	147,190	11,833	28,859	187,882	(15,376)	172,506	(73,148)	99,358		21
22	Employee Benefits & Payroll Taxes			843,040	843,040		843,040		843,040		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,634	2,634		2,634		2,634		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			16,600	16,600		16,600		16,600		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>209,113</b>	<b>11,833</b>	<b>933,651</b>	<b>1,154,597</b>	<b>(15,376)</b>	<b>1,139,221</b>	<b>(77,729)</b>	<b>1,061,492</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,914,094</b>	<b>515,894</b>	<b>1,816,155</b>	<b>5,246,143</b>	<b>(361)</b>	<b>5,245,782</b>	<b>(302,220)</b>	<b>4,943,562</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

PIATT COUNTY NURSING HOME

#0020255

Report Period Beginning:

12-01-05

Ending:

11-30-06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			121,487	121,487		121,487		121,487			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(3,357)	(3,357)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			3,480	3,480		3,480		3,480			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			124,967	124,967		124,967	(3,357)	121,610			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			1,265,518	1,265,518		1,265,518	(1,210,768)	54,750			42
43	Other (specify):* <b>PCSS,FIA,BAER</b>	58,542	4,382	21,940	84,864	361	85,225	(84,864)	361			43
44	<b>TOTAL Special Cost Centers</b>	58,542	4,382	1,287,458	1,350,382	361	1,350,743	(1,295,632)	55,111			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,972,636	520,276	3,228,580	6,721,492		6,721,492	(1,601,209)	5,120,283			45

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

Facility Name & ID Number PIATT COUNTY NURSING HOME

# 0020255

Report Period Beginning: 12-01-05

Ending: 11-30-06

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients	(675)	2,11		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(216,204)	1,2		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	(3,357)	32		10
11	Discounts, Allowances, Rebates & Refunds	(130)	7		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	(972)	20		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	162,338	3,15,21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (59,000)</b>		<b>\$</b>	<b>30</b>

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)	6,302	CTY EMI	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 6,302</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (52,698)</b>		<b>37</b>

\*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.			\$	14	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

PIATT COUNTY NURSING HOME

ID# 0020255

Report Period Beginning: 12-01-05

Ending: 11-30-06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	DIET SUPPLIES-KIRBY	\$ (3,156)	1	1
2	VOLUNTEER COURTESY CART	(264)	15	2
3	N TRAINING EXPENSE RECOVERY	(907)	13	3
4	OPERATING INCOME-FOUNDATION REIMBURSE	(73,148)	21	4
5	JURY DUTY RECOVERY	0	21	5
6	PCSS, FIA, BAER	(84,864)	43	6
7	IGT	(1,210,768)	42	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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19				19
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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	<b>Total</b>	(1,373,106)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number **PIATT COUNTY NURSING HOME**# **0020255**

Report Period Beginning:

**12-01-05**

Ending:

**11-30-06****SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(3,156)	0	0	0	0	0	0	0	0	0	0	(3,156)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	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):*	(130)	0	0	0	0	0	0	0	0	0	0	(130)	7
8	<b>TOTAL General Services</b>	<b>(3,286)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,286)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	(907)	0	0	0	0	0	0	0	0	0	0	(907)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(264)	0	0	0	0	0	0	0	0	0	0	(264)	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,170)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,170)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	5,696	0	0	0	0	0	0	0	0	0	5,696	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(972)	0	0	0	0	0	0	0	0	0	0	(972)	20
21	Clerical & General Office Expenses	(73,148)	606	0	0	0	0	0	0	0	0	0	(72,542)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(74,120)</b>	<b>6,302</b>	<b>0</b>	<b>(67,818)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(78,576)</b>	<b>6,302</b>	<b>0</b>	<b>(72,274)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number PIATT COUNTY NURSING HOME# 0020255 Report Period Beginning:

12-01-05 Ending:

11-30-06

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
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	(3,357)	0	0	0	0	0	0	0	0	0	0	(3,357) 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	<b>TOTAL Ownership</b>	<b>(3,357)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,357) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	(1,210,768)	0	0	0	0	0	0	0	0	0	0	(1,210,768) 42
43	Other (specify):*	(84,864)	0	0	0	0	0	0	0	0	0	0	(84,864) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,295,632)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,295,632) 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(1,377,565)</b>	<b>6,302</b>	<b>0</b>	<b>(1,371,263) 45</b>								

Facility Name & ID Number **PIATT COUNTY NURSING HOME**

# **0020255**

Report Period Beginning:

**12-01-05**

Ending:

**11-30-06**

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

**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	18 NSG HOME COMMITTEE MTC	\$		100.00%	\$ 5,696	\$ 5,696 1
2	V	21 IMRF/FICA		COUNTY CLERKS OFFICE	100.00%	287	287 2
3	V	HEALTH INSURANCE REPORTS					3
4	V	FEDERAL & IL INCOME TAX					4
5	V	UNEMPLOYMENT COMP REPORT					5
6	V	21 RECONCILING BANK STATEMENTS		COUNTY TREASURER	100.00%	319	319 6
7	V	RECORDING CHECKS A/P & P/R					7
8	V	CHECK SIGNING;FUNDED DEPR.					8
9	V						9
10	V						10
11	V						11
12	V	22 IMRF/FICA			100.00%	437,988	12
13	V	22 UNEMP COMP & HEALTH INS			100.00%	334,418	13
14	Total		\$			\$ 778,708	\$ * 6,302 14

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

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	N/A								\$	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 PIATT COUNTY NURSING HOME # 0020255 Report Period Beginning: 12-01-05 Ending: 11-30-06

**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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

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	N/A				\$	\$		\$	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	<b>TOTALS</b>				\$	\$		\$	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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1							\$	\$			\$	1								
2	N/A											2								
3												3								
4												4								
5												5								
	<b>Working Capital</b>																			
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$	\$			\$	9								
	<b>B. Non-Facility Related*</b>																			
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	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.)

Facility Name & ID Number **PIATT COUNTY NURSING HOME**# **0020255** Report Period Beginning: **12-01-05** Ending: **11-30-06****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2005 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	N/A	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).			\$	#VALUE!	3
4. Real Estate Tax accrual used for 2006 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	#VALUE!	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2001 _____ 8			
		2002 _____ 9			
		2003 _____ 10			
		2004 _____ 11			
		2005 _____ 12			
			<b>FOR BHF USE ONLY</b>		
			13	FROM R. E. TAX STATEMENT FOR 2005 \$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME PIATT COUNTY NURSING HOME COUNTY PIATT

FACILITY IDPH LICENSE NUMBER 0020255

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number PIATT COUNTY NURSING HOME# 0020255 Report Period Beginning:12-01-05 Ending:11-30-06**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 37,120 B. General Construction Type: Exterior BRICK Frame COMB W/SPRINKLE Number of Stories 1C. 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).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY COST</u>	<u>182,592</u>	<u>1973</u>	<u>\$ 35,000</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>182,592</u>		<u>\$ 35,000</u>	<u>3</u>

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	60	1973	1970	\$ 800,000	\$	30	\$	\$	\$ 800,000
5	36	1975	1974	525,102	28	30	28		525,081
6	4	1989	1989	863,408	28,780	30	28,780		503,652
7	BLDG PROJ	1993	1992	244,299	8,144	30	8,144		109,940
8									
<b>Improvement Type**</b>									
9	BUILDING IMPROVEMENTS		1976	7,130		20			7,130
10			1977	8,236		20			8,236
11			1978	541		20			541
12			1979	4,254		20			4,254
13			1980	170,832		20			170,832
14			1981	6,276		20			6,276
15			1982	6,960		20			6,960
16			1983	56,871		20			56,871
17			1984	1,490		5			1,490
18			1984	1,831		10			1,831
19			1984	7,260		20			7,260
20			1985	962		5			962
21			1985	18,315		20			18,315
22			1986	6,415		10			6,415
23			1986	5,472	132	20	132		5,472
24			1987	7,987		5			7,987
25			1987	3,597		10			3,597
26			1987	1,000		15			1,000
27			1987	1,509	75	20	75		1,466
28			1988	5,395		5			5,395
29			1988	22,150		15			22,150
30			1988	22,737	1,137	20	1,137		21,033
31			1989	72,494		15			72,494
32			1989	18,169		5			18,169
33			1990	13,836		15			13,836
34			1991	1,120		5			1,120
35			1991	2,890		10			2,890
36			1991	44,194	1,475	15	1,475		44,194

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number PIATT COUNTY NURSING HOME

# 0020255

Report Period Beginning:

12-01-05

Ending:

11-30-06

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	BUILDING IMPROVEMENT	1992	\$ 5,532	\$	10	\$	\$	\$ 5,532	37
38	BUILDING IMPROVEMENT	1993	21,036		10			21,036	38
39	BUILDING IMPROVEMENT	1994	5,888		10			5,888	39
40	BUILDING IMPROVEMENT	1995	8,381		10			8,381	40
41	BLDG IMP-remodel admin office, ARD room,, replace crash cart	1996	7,582	380	10	380		7,582	41
42	BLDG IMP-NEW PIPES & NEW ROOF	1997	227,748	11,388	20	11,388		108,181	42
43	BLDG IMP-new water heater	1998	5,377	358	15	358		3,046	43
44	BLDG IMP-paint rooms & halls,water heater install	1998	4,046	202	20	202		1,719	44
45	BLDG IMP-security system,heat pump	1999	17,009		5			17,009	45
46	BLDG IMP-kitchen remodel,Halcyon roof & remodel	1999	85,221	4,261	20	4,261		31,958	46
47	BLDG IMP-telephone & wiring,handicap door, carrier units	2000	13,585	1,359	10	1,359		9,509	47
48	BLDG IMP-patient overhead lights,dining room remodel	2000	23,373	1,558	10	1,558		10,907	48
49	BLDG IMP-resident room & common area remodeling	2001	46,868	4,687	10	4,687		28,122	49
50	BLDG IMP-carrier units	2001	3,080	205	15	205		1,232	50
51	BLDG IMP-garage roof & feasibility study	2002	4,588	459	10	459		2,065	51
52	BLDG IMP-overbed lights,closet doors,convectors	2002	21,597	1,440	15	1,440		6,480	52
53	BLDG IMP-tile work in shower rooms	2002	2,267	113	20	113		510	53
54	BLDG IMP-sprinkler work	2003	9,840	394	8	394		1,378	54
55	BLDG IMP-Halcyon kitchen,beauty shop,admin roof,entry door &	2004	13,838	1,384	10	1,384		3,460	55
56	BLDG IMP-Halcyon awning & convectors	2004	5,108	341	15	341		852	56
57	BLDG IMP-shower repair	2004	985	49	20	49		123	57
58	BLDG IMP-acct office remodel,paint & tiles,motor for boiler pump	2005	676	68	10	68		102	58
59	BLDG IMP-a/c 1st & 2nd stage compressors	2005	12,416	828	15	828		1,242	59
60	BLDG IMP-nurse call system,fire wall work	2006	68,545	3,427	10	3,427		3,427	60
61	BLDG IMP-concrete sidewalk	2006	5,695	190	15	190		190	61
62	BLDG IMP-sewer replacement & repair	2006	7,193	144	25	144		144	62
63	GROUNDS IMPROVEMENT	1976	954		10			954	63
64	GROUNDS IMPROVEMENT	1977	2,298		10			2,298	64
65	GROUNDS IMPROVEMENT	1978	1,729		10			1,729	65
66	GROUNDS IMPROVEMENT	1979	6,235		10			6,235	66
67	GROUNDS IMPROVEMENT	1980	3,031		10			3,031	67
68	GROUNDS IMPROVEMENT	1981	2,803		10			2,803	68
69	GROUNDS IMPROVEMENT	1982	1,196		10			1,196	69
70	TOTAL (lines 4 thru 69)		\$ 3,598,452	\$ 73,006		\$ 73,006	\$	\$ 2,755,170	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,598,452	\$ 73,006		\$ 73,006		\$ 2,755,170	1
2	GROUNDS IMPROVEMENT	1983	1,212		12			1,212	2
3	GROUNDS IMPROVEMENT	1984	7,796		10			7,796	3
4	GROUNDS IMPROVEMENT	1986	1,077		10			1,077	4
5	GROUNDS IMPROVEMENT	1987	6,713		3			6,713	5
6	GROUNDS IMPROVEMENT	1987	1,118		10			1,118	6
7	GROUNDS IMPROVEMENT	1989	11,701		10			11,701	7
8	GROUNDS IMPROVEMENT	1990	2,682		10			2,682	8
9	GROUNDS IMPROVEMENT	1992	51,409		10			51,409	9
10	GROUNDS IMPROVEMENT	1993	4,988		10			4,988	10
11	GRND IMP-New sign front/rear ent;restripe lot	1996	9,884	495	10	495		9,884	11
12	GRND IMP-Tree remodel & excavation	1998	8,691						12
13	GRND IMP-ARD awnings;truck turnaround;sidewalk rail	1998	6,361	646	10	646		5,491	13
14	GRND IMP-Tile repair	1999	765	77	10	77		575	14
15	GRND IMP-Concrete pation	2000	2,107	211	10	211		1,475	15
16	GRND IMP-Landscaping	2001	1,850	1,860	5	1,860		1,850	16
17	GRND IMP-Surfacing;striping;patching parking lot	2003	14,884		8			6,512	17
18	GASB 34 Adj in 2004	2004	(16,641)					(16,641)	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,715,149	\$ 76,295		\$ 76,295		\$ 2,853,012	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 419,907	\$ 39,816	\$ 39,816	\$		\$ 240,672	71
72	Current Year Purchases	48,081	4,916	4,916			4,916	72
73	Fully Depreciated Assets	493,096	463	463			493,096	73
74								74
75	TOTALS	\$ 961,084	\$ 45,195	\$ 45,195	\$		\$ 738,684	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	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)	\$ 4,711,233	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 121,490	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 121,490	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)	\$ 3,591,696	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	AL Architect Fees	\$ 37,620	92
93			93
94			94
95		\$ 37,620	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
 If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1975	STORAGE RENT		\$ 3,480	N/A	N/A	3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ 3,480			7

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.	/2007	\$ _____
13.	/2008	\$ _____
14.	/2009	\$ _____

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	<b>TOTAL</b>		\$ _____	\$ _____	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

**A. TYPE OF TRAINING PROGRAM** (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input checked="" type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	92	\$	\$ 92
2	Books and Supplies		58		58
3	Classroom Wages (a)		3,613		3,613
4	Clinical Wages (b)		1,780		1,780
5	In-House Trainer Wages (c)				
6	Transportation		813		813
7	Contractual Payments				
8	CNA Competency Tests		104		104
9	<b>TOTALS</b>	\$	6,460	\$	\$ 6,460
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,460		

**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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>3</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Total Units	Total Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10A,3	hrs	\$	1,846	\$ 31,475					1,846	\$ 31,475	1	
2	Licensed Speech and Language Development Therapist	10A,3	hrs		217	9,887					217	9,887	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	10A,3	hrs		2,839	42,586					2,839	42,586	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	10A,2	# of prescripts						71,652			71,652	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify):												13	
14	<b>TOTAL</b>			\$	4,902	\$ 83,948			\$ 71,652		4,902	\$ 155,600	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.

STATE OF ILLINOIS

Facility Name & ID Number PIATT COUNTY NURSING HOME

# 0020255

Report Period Beginning: 12-01-05

Ending:

11-30-06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11-30-06

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 104,204	\$ 292,123 1
2	Cash-Patient Deposits		4,420 2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	457,135	841,110 3
4	Supply Inventory (priced at )	37,606	37,606 4
5	Short-Term Investments		5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	742	742 7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 599,687</b>	<b>\$ 1,176,001 10</b>
<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	35,000	35,000 13
14	Buildings, at Historical Cost	3,752,769	3,752,769 14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	961,084	961,084 16
17	Accumulated Depreciation (book methods)	(3,591,689)	(3,591,689) 17
18	Deferred Charges		18
19	Organization & Pre-Operating Costs		19
20	Accumulated Amortization - Organization & Pre-Operating Costs		20
21	Restricted Funds		21
22	Other Long-Term Assets (specify):		22
23	Other(specify):		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 1,157,164</b>	<b>\$ 1,157,164 24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 1,756,851</b>	<b>\$ 2,333,165 25</b>

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 161,113	\$ 161,113 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	102,663	102,663 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
<b>Other Current Liabilities(specify):</b>			
36	<b>EMPLOYEE BENEFITS</b>	<b>275,524</b>	<b>275,524 36</b>
37	<b>RESIDENT REFUNDS</b>		<b>4,420 37</b>
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 539,300</b>	<b>\$ 543,720 38</b>
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$</b>	<b>\$ 45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 539,300</b>	<b>\$ 543,720 46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 1,217,551</b>	<b>\$ 1,789,445 47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 1,756,851</b>	<b>\$ 2,333,165 48</b>

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,088,314</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,088,314</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>129,237</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>129,237</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,217,551</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number PIATT COUNTY NURSING HOME

# 0020255

Report Period Beginning: 12-01-05

Ending:

11-30-06

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,721,256	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,721,256	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients	1,050	5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,050	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,923	11
12	Gift and Coffee Shop	264	12
13	Barber and Beauty Care	2,481	13
14	Non-Patient Meals	128,290	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	3,156	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 136,114	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,187	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,187	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	SEE ATTACHED SCHEDULE	998,475	28
28a	INTERFUND TRANSFERS	(9,353)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 989,122	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,850,729	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,193,503	31
32	Health Care	2,898,043	32
33	General Administration	1,154,597	33
<b>B. Capital Expense</b>			
34	Ownership	124,967	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,350,382	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,721,492	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	129,237	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 129,237	43

\* 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.

Facility Name & ID Number **PIATT COUNTY NURSING HOME**

# 0020255

Report Period Beginning: 12-01-05

Ending: 11-30-06

## 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	1,392	1,773	\$ 47,892	\$ 27.01	1
2	Assistant Director of Nursing	1,594	1,931	46,146	23.90	2
3	Registered Nurses	16,843	18,834	450,162	23.90	3
4	Licensed Practical Nurses	10,430	12,260	248,949	20.31	4
5	CNAs & Orderlies	82,022	88,296	1,052,496	11.92	5
6	CNA Trainees		467	5,393	11.55	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	347	347	4,863	14.01	9
10	Activity Assistants	9,155	10,262	110,190	10.74	10
11	Social Service Workers	2,652	3,174	37,373	11.77	11
12	Dietician					12
13	Food Service Supervisor	1,884	2,330	44,885	19.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,096	33,975	326,535	9.61	15
16	Dishwashers					16
17	Maintenance Workers	9,076	10,825	138,929	12.83	17
18	Housekeepers	9,920	11,187	103,477	9.25	18
19	Laundry	3,153	3,369	29,828	8.85	19
20	Administrator	1,924	2,197	61,923	28.19	20
21	Assistant Administrator					21
22	Other Administrative	8,589	10,110	147,189	14.56	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	559	559	14,148	25.31	32
33	Other(specify) <u>SEE ATTACHED</u>					33
34	TOTAL (lines 1 - 33)	190,636	211,896	\$ 2,870,378 *	\$ 13.55	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	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,545	\$ 105,819	50
51	Licensed Practical Nurses	6,060	194,441	51
52	Certified Nurse Assistants/Aides	7,507	146,151	52
53	TOTAL (lines 50 - 52)	16,112	\$ 446,411	53





**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. INHAA \$100, LSN \$4860, CNHA \$980
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 7.5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,807 Line NO
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,750  
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? YES If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 15,390
- (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. \$ 0  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: MAY, COCAGNE & KING, PC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

Cost Report Schedule V	Nursing	Social Service	Activities	Volunteers	Dietary	Maintenance	Housekeeping	Admin	Nursing Transport	Faith In Action	Employee Benefits	Medical Transport	Plant Operation
Transportation Medical Purposes Resident	0	0	0	0	0	0	0	0	0	0	0	0	0
Admin - Clerical	6610	0	175	0	582	0	0	-7367	0	0	0	0	0
Telephone Expense	2829	793	0	0	793	678	0	-5093	0	0	0	0	0
Copier Expense	1370	404	154	4	261	52	310	-2915	0	361	0	0	0
<b>Total</b>	<b>10809</b>	<b>1197</b>	<b>329</b>	<b>4</b>	<b>1636</b>	<b>730</b>	<b>310</b>	<b>-15375</b>	<b>0</b>	<b>361</b>	<b>0</b>	<b>0</b>	<b>0</b>
Line #	10	12	11	15	1	6	3	21	14	43	22	38	6

PCNH  
Income Statement Revenue  
November 30, 2006

Schedule XVII, Line 28, Other Revenue

Jury Duty Recovery	0
NA Training	907
Contractual Recovery	130
Write Off Accounts Receivable	-1148
Gain/Loss - Sale of Assets	-166
Foundation Contribution	69578
PCSS Income	53082
FIA Income	41495
Transfers from County	832406
Baer Property Revenue	2025
Department Head Consulting	<u>166</u>
Total	998475

PCNH 2006  
Cost Center Expenses  
Supporting Schedules

Schedule V, Line 7, General Services

Materials Management	
Salaries	8205
Other Expense	137
Other Supplies	999
	<u>9341</u>

Schedule V, Line 15, Health Care Programs

Volunteer Program Coordinator	
Salaries	17604
Courtesy Cart Supplies	207
Other Supplies	213
Staff Development	-62
Service On Demand	83
Travel	10
	<u>18055</u>

Schedule V, Line 43, Special Cost Centers

Platt County Services for Seniors	
Salaries & Wages	38400
Telephone Expense	1908
Postage Expense	472
Copier Expense	199
Supplies	1000
Secretarial Service	2470
Rental Expense	1800
Insurance Expense	355
Equipment	494
Travel	3595
Pamphlets	385
	<u>51078</u>

Platt County Nursing Home serves as the Grant Sponsor for this agency which is chiefly supported by an Area Agency Grant. All expenses for this agency have been eliminated on Schedule V, Line 43.

**Faith In Action**

Salaries & Wages	20142
Telephone	920
Postage	1416
Copier Expense	115
Supplies	795
Marketing Expense	320
Volunteer Recognition & Training	805
Insurance Expense	906
Staff Development	1178
Rent	960
Travel	428
Equipment & Equipment Repair	1320
Fundraising	249
Dues & Fees	50
	<u>29604</u>

Platt County Nursing Home serves as the Grant Sponsor for this agency which is chiefly supported by miscellaneous grants & donations. All expenses for this agency have been eliminated on Schedule V, Line 43.

**Baer Property**

Service on Demand	150
Property Taxes	3274
Insurance	770
Repairs	15
	<u>4209</u>

This property expense is incurred on Platt County Nursing Home Foundation property. All expenses have been eliminated from Schedule V, Line 43.

**Intergovernmental Transfers** 1210768

Platt County Nursing Home is a participant in Illinois Funds. This amount has been eliminated on Schedule V, Line 42.

PCNH  
Support Schedule  
30-Nov-06

Schedule XIV, Section G - Schedule of Travel & Seminar

Seminar Expense - Staff Development

K. Bradley, Executive Director LSN Annual Convention LSN, Chicago, IL 04/05/06 - 04/07/06	604
S. Craig, Personnel Director MDI Software Training MDI, St. Louis, MO 03/21/06 - 03/23/06	193
S. Craig, Personnel Director How To Be Postive Without Really Trying Carle, Champaign, IL 3/30/07	0
S. Craig, Personnel Director SHIP Conference SHIP, Bloomington, IL 10/13/06	34
S. Craig, Personnel Director Resident Criminal Background Checks LSN, Audio Conference, 11/01/06	99
R. Clarkson, Personnel Coordinator MDI Software Training MDI, St. Louis, MO 03/21/06 - 03/23/06	193
E. Cheek, Accounting Coordinator MDI Software Training MDI, St. Louis, MO 03/21/06 - 03/23/06	193
E. Cheek, Accounting Coordinator Effective Accounts Receivable Management SMSI, Champaign, IL 8/24/06	69
E. Cheek, Accounting Coordinator Benefits Exhaust & No Payment SNF Billing SMSI, Audio Conference 9/12/06	90
E. Cheek, Accounting Coordinator Getting A Handle On the New No Pay Process LSN, Audio Conference, 11/28/06	57
C. Summers, Accounting Assistant MDI Software Trainging MDI, St. Louis, MO 03/21/06 - 03/23/06	192
Total	1724