

Facility Name & ID Number Piatt County Nursing Home

0020255 Report Period Beginning: 12-01-06 Ending: 11-30-07

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	357	970		1,327	8
9	SNF/PED					9
10	ICF	17,228	16,999		34,227	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,585	17,969		35,554	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.41%

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 at Kirby Hospital, Piatt County Jail Meals

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/1/1973

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: _____ Fiscal Year: _____

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

STATE OF ILLINOIS

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12-01-06 Ending: 11-30-07

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	383,681	32,480	12,434	428,595	1,816	430,411	(175,378)	255,033		1
2	Food Purchase		264,221		264,221		264,221	(74,761)	189,460		2
3	Housekeeping	114,799	16,825	954	132,578	3	132,581		132,581		3
4	Laundry	31,089	13,139	105,088	149,316		149,316		149,316		4
5	Heat and Other Utilities			97,403	97,403		97,403		97,403		5
6	Maintenance	124,077	14,046	36,318	174,441	777	175,218		175,218		6
7	Other (specify):* Materials Mgmt	9,525	87	1,239	10,851		10,851	(1,295)	9,556		7
8	TOTAL General Services	663,171	340,798	253,436	1,257,405	2,596	1,260,001	(251,434)	1,008,567		8
B. Health Care and Programs											
9	Medical Director			1,300	1,300		1,300		1,300		9
10	Nursing and Medical Records	1,957,624	177,409	459,666	2,594,699	10,515	2,605,214		2,605,214		10
10a	Therapy		37	130,356	130,393		130,393		130,393		10a
11	Activities	115,163	2,511	1,750	119,424	337	119,761		119,761		11
12	Social Services	36,990	935	2,105	40,030	1,148	41,178		41,178		12
13	CNA Training	3,007		779	3,786		3,786	(1,280)	2,506		13
14	Program Transportation			737	737		737		737		14
15	Other (specify):* Volunteers	18,011	539	187	18,737	33	18,770	(254)	18,516		15
16	TOTAL Health Care and Programs	2,130,795	181,431	596,880	2,909,106	12,033	2,921,139	(1,534)	2,919,605		16
C. General Administration											
17	Administrative	63,194			63,194		63,194		63,194		17
18	Directors Fees							5,696	5,696		18
19	Professional Services			8,985	8,985		8,985		8,985		19
20	Dues, Fees, Subscriptions & Promotions			19,383	19,383		19,383	(1,730)	17,653		20
21	Clerical & General Office Expenses	150,855	16,129	37,266	204,250	(14,800)	189,450	(185,534)	3,916		21
22	Employee Benefits & Payroll Taxes			823,892	823,892		823,892		823,892		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,559	3,559		3,559		3,559		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	TOTAL General Administration	214,049	16,129	909,685	1,139,863	(14,800)	1,125,063	(181,568)	943,495		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,008,015	538,358	1,760,001	5,306,374	(171)	5,306,203	(434,536)	4,871,667		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.

Facility Name & ID Number

Piatt County Nursing Home

#0020255

Report Period Beginning:

12-01-06

Ending:

11-30-07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			125,595	125,595		125,595		125,595		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							(5,508)	(5,508)		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	TOTAL Ownership			129,075	129,075		129,075	(5,508)	123,567		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			1,346,595	1,346,595		1,346,595	(1,291,782)	54,813		42
43	Other (specify):*	64,653	5,057	17,200	86,910	171	87,081	(86,791)	290		43
44	TOTAL Special Cost Centers	64,653	5,057	1,363,795	1,433,505	171	1,433,676	(1,378,573)	55,103		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,072,668	543,415	3,252,871	6,868,954		6,868,954	(1,818,617)	5,050,337		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 **Platt County Nursing Home**

0020255

Report Period Beginning: **12-01-06**

Ending: **11-30-07**

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients	(510)	2,11		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(247,937)	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	(5,508)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,295)	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	(1,054)	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	(276,647)	3,15,21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (532,951)		\$	30

BHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	6,302	Cty Emp	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,302		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (526,649)		37

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

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

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

Piatt County Nursing Home

ID# 0020255

Report Period Beginning: 12-01-06

Ending: 11-30-07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Diet Supplies - Kirby	\$ (2,182)	1	1
2	Volunteer Courtesy Cart	(254)	15	2
3	NA Training Expense Recovery	(1,280)	13	3
4	Operating Income - Foundation Reimbursement	(186,140)	21	4
5	PCSS, FIA, Baer	(86,791)	43	5
6	IGT	(1,291,782)	42	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,568,429)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Piatt County Nursing Home

0020255

Report Period Beginning:

12-01-06

Ending:

11-30-07

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)	
	A. General Services													
1	Dietary	(2,182)	0	0	0	0	0	0	0	0	0	0	(2,182)	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):*	(1,295)	0	0	0	0	0	0	0	0	0	0	(1,295)	7
8	TOTAL General Services	(3,477)	0	0	0	0	0	0	0	0	0	0	(3,477)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	(1,280)	0	0	0	0	0	0	0	0	0	0	(1,280)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(254)	0	0	0	0	0	0	0	0	0	0	(254)	15
16	TOTAL Health Care and Programs	(1,534)	0	0	0	0	0	0	0	0	0	0	(1,534)	16
	C. General Administration													
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	(1,054)	0	0	0	0	0	0	0	0	0	0	(1,054)	20
21	Clerical & General Office Expenses	(186,140)	606	0	0	0	0	0	0	0	0	0	(185,534)	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	TOTAL General Administration	(187,194)	6,302	0	(180,892)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(192,205)	6,302	0	(185,903)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Platt County Nursing Home# 0020255

Report Period Beginning:

12-01-06

Ending:

11-30-07

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(5,508)	0	0	0	0	0	0	0	0	0	0	(5,508) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(5,508)	0	0	0	0	0	0	0	0	0	0	(5,508) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	(1,291,782)	0	0	0	0	0	0	0	0	0	0	(1,291,782) 42
43	Other (specify):*	(86,791)	0	0	0	0	0	0	0	0	0	0	(86,791) 43
44	TOTAL Special Cost Centers	(1,378,573)	0	0	0	0	0	0	0	0	0	0	(1,378,573) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,576,286)	6,302	0	(1,569,984) 45								

Facility Name & ID Number Piatt County Nursing Home

0020255

Report Period Beginning: 12-01-06

Ending: 11-30-07

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 Nursing Home Committee	\$		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	Fed & 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 AP & PR							7
8	V	Check Signing; Funded Dep.							8
9	V								9
10	V								10
11	V								11
12	V	22 IMRF			100.00%	201,755			12
13	V	22 Unemp. Comp. & Health Insurance			100.00%	320,896			13
14	Total		\$			\$ 528,953	\$ *	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									\$		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: 12-01-06 Ending: 11-30-07

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					\$	\$			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.)

Facility Name & ID Number **Piatt County Nursing Home**# **0020255** Report Period Beginning: **12-01-06** Ending: **11-30-07****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2006 report.			\$	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	3
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2002	_____	8	
		2003	_____	9	
		2004	_____	10	
		2005	_____	11	
		2006	_____	12	
FOR BHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2006		\$		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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Platt County Nursing Home COUNTY Platt

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 2006 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 2006.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

A. Square Feet: 37,120 B. General Construction Type: Exterior Brick Frame Comb/Sprinkler 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. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility Cost	182,592	1973	\$ 35,000	1
2					2
3	TOTALS	182,592		\$ 35,000	3

Facility Name & ID Number Platt County Nursing Home

0020255

Report Period Beginning:

12-01-06

Ending:

11-30-07

XL 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	21	30	21		525,102
6	4	1989	1989	863,408	28,780	30	28,780		532,432
7	Bldg Proj	1993	1992	244,299	8,143	30	8,143		118,083
8									
Improvement Type**									
9	Building Improvement		1976	7,130		20			7,130
10	Building Improvement		1977	8,236		20			8,236
11	Building Improvement		1978	541		20			541
12	Building Improvement		1979	4,254		20			4,254
13	Building Improvement		1980	170,832		20			170,832
14	Building Improvement		1981	6,276		20			6,276
15	Building Improvement		1982	6,960		20			6,960
16	Building Improvement		1983	56,871		20			56,871
17	Building Improvement		1984	1,490		5			1,490
18	Building Improvement		1984	1,831		10			1,831
19	Building Improvement		1984	7,260		20			7,260
20	Building Improvement		1985	962		5			962
21	Building Improvement		1985	18,315		20			18,315
22	Building Improvement		1986	6,415		10			6,415
23	Building Improvement		1986	5,472		20			5,472
24	Building Improvement		1987	7,987		5			7,987
25	Building Improvement		1987	3,597		10			3,597
26	Building Improvement		1987	1,000		15			1,000
27	Building Improvement		1987	1,509	43	20	43		1,509
28	Building Improvement		1988	5,395		5			5,395
29	Building Improvement		1988	22,150		15			22,150
30	Building Improvement		1988	22,737	1,137	20	1,137		22,170
31	Building Improvement		1989	72,494		15			72,494
32	Building Improvement		1989	18,169		5			18,169
33	Building Improvement		1990	13,836		15			13,836
34	Building Improvement		1991	1,120		5			1,120
35	Building Improvement		1991	2,890		10			2,890
36	Building Improvement		1991	44,194		15			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 & ID Number Piatt County Nursing Home# 0020255

Report Period Beginning:

12-01-06

Ending:

11-30-07**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: Admin Office & ARD Remodel; Crash Carts 50' & 60's	1996	7,582		10			7,582		41
42	Bldg. Imp: New Pipes & New Roof	1997	227,748	11,388	20	11,388		119,569		42
43	Bldg. Imp: New Water Heater	1998	5,377	358	15	358		3,404		43
44	Bldg. Imp: Patient Rooms & Halls; Water Heater Install	1998	4,046	202	20	202		1,921		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		36,219		46
47	Bldg. Imp: Telephone & Wiring; Handicap door; Carrier Units	2000	13,585	1,359	10	1,359		10,868		47
48	Bldg. Imp: Patient Overbed Lights; Dining Room Remodel	2000	23,373	1,558	10	1,558		12,465		48
49	Bldg. Imp: Resident Room & Common Area Remodeling	2001	46,868	4,687	10	4,687		32,809		49
50	Bldg. Imp: Carrier Units	2001	3,080	205	15	205		1,437		50
51	Bldg. Imp: Garage & Feasibility	2002	4,588	459	10	459		2,524		51
52	Bldg. Imp: Overbed Lights; Closet Doors; Convector	2002	21,597	1,440	15	1,440		7,920		52
53	Bldg. Imp: Tile Work in Shower Rooms	2002	2,267	113	20	113		623		53
54	Bldg. Imp: Sprinkler Work	2003	9,840	394	8	394		1,772		54
55	Bldg. Imp: Halcyon Kitchen; Beauty Shop; Admin Roof; Entry Door	2004	13,838	1,384	10	1,384		4,844		55
56	Bldg. Imp: Halcyon Awning & Convector	2004	5,108	341	15	341		1,193		56
57	Bldg. Imp: Shower Repair	2004	985	49	20	49		172		57
58	Bldg. Imp: Act. Office Remodel; Paint & Tile; Motor for Boiler	2005	676	68	10	68		170		58
59	Bldg. Imp: Air Cond. 1st & 2nd Stage Compressors	2005	12,416	828	15	828		2,070		59
60	Bldg. Imp: Nurse Call System; Fire Wall Work	2006	68,545	6,855	10	6,855		10,282		60
61	Bldg. Imp: Concrete Sidewalk	2006	5,695	380	15	380		570		61
62	Bldg. Imp: Sewer Replacement & Repair	2006	7,193	288	25	288		432		62
63	Bldg. Imp: Admin Carpet	2007	2,552	255	5	255				63
64	Bldg. Imp: Dining & Kitchen Roof; Oasis Flooring	2007	8,265	590	7	590				64
65	Grounds Improvement	1976	954		10			954		65
66	Grounds Improvement	1977	2,298		10			2,298		66
67	Grounds Improvement	1978	1,729		10			1,729		67
68	Grounds Improvement	1979	6,235		10			6,235		68
69	Grounds Improvement	1980	3,031		10			3,031		69
70	TOTAL (lines 4 thru 69)		\$ 3,605,270	\$ 75,586		\$ 75,586	\$	\$ 2,825,912		70

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

STATE OF ILLINOIS

Facility Name & ID Number Piatt County Nursing Home

0020255

Report Period Beginning:

12-01-06

Ending:

11-30-07

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		\$ 3,605,270	\$ 75,586		\$ 75,586		\$ 2,825,912	1
2	Grounds Improvements	1981	2,803		10			2,803	2
3	Grounds Improvements	1982	1,196		10			1,196	3
4	Grounds Improvements	1983	1,212		12			1,212	4
5	Grounds Improvements	1984	7,796		10			7,796	5
6	Grounds Improvements	1986	1,077		10			1,077	6
7	Grounds Improvements	1987	6,713		3			6,713	7
8	Grounds Improvements	1987	1,118		10			1,118	8
9	Grounds Improvements	1989	11,701		10			11,701	9
10	Grounds Improvements	1990	2,682		10			2,682	10
11	Grounds Improvements	1992	51,409		10			51,409	11
12	Grounds Improvements	1993	4,988		10			4,988	12
13	Grnd. Imp: New Sign front/rear entrance; retriage lot	1996	9,884		10			9,884	13
14	Grnd. Imp: Tree Removal & Excavation	1998	8,691						14
15	Grnd. Imp: ARD Awning; Truck Turnaround; Sidewalk	1998	6,461	646	10	646		6,137	15
16	Grnd. Imp: Tile Repair	1999	765	77	10	77		652	16
17	Grnd Imp: Concrete Patio	2000	2,107	211	10	211		1,686	17
18	Grnd. Imp: Landscaping	2001	1,850		5			1,850	18
19	Grnd. Imp: Surfacing, Striping & Patching of Parking Lot	2003	14,884	1,861	8	1,861		8,374	19
20	GASB 34 Adj in 2004	2004	(16,641)					(16,641)	20
21	Grnd. Imp: Drive Resurfacing	2007	1,300	43	5	43		43	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)		\$ 3,727,266	\$ 78,424		\$ 78,424		\$ 2,930,592	34

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

Facility Name & ID Number Piatt County Nursing Home

0020255

Report Period Beginning:

12-01-06

Ending:

11-30-07

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	\$ 404,986	\$ 43,230	\$ 43,230	\$		\$ 219,739	71
72	Current Year Purchases	18,114	1,174	1,174			1,174	72
73	Fully Depreciated Assets	543,711	2,767	2,767			554,059	73
74								74
75	TOTALS	\$ 966,811	\$ 47,171	\$ 47,171	\$		\$ 774,972	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 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)	\$ 4,729,077	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 125,595	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,595	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)	\$ 3,705,564	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	AL Architect Fees	\$ 266,678	92
93			93
94			94
95		\$ 266,678	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	NA	NA	3
4	Additions							4
5								5
6								6
7	TOTAL				\$ 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.	/2008	\$ _____
13.	/2009	\$ _____
14.	/2010	\$ _____

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

* 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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u> 80 </u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u> 40 </u></p>
---	--	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 64	\$	\$ 64
2	Books and Supplies				
3	Classroom Wages (a)		1,761		1,761
4	Clinical Wages (b)		1,246		1,246
5	In-House Trainer Wages (c)		613		613
6	Transportation		102		102
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 3,786	\$	\$ 3,786
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,786		

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (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	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	10a, 3	hrs	\$	2,282	\$ 46,186	\$	2,282	\$ 46,186	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		571	25,996		571	25,996	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		2,941	58,174		2,941	58,174	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10, 2	# of prescripts				56,423		56,423	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	TOTAL			\$	5,794	\$ 130,356	\$ 56,423	5,794	\$ 186,779	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: **12-01-06**

Ending:

11-30-07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **11-30-07**

(last day of reporting year)

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	\$ 653,203	\$ 1,145,099
2	Cash-Patient Deposits		6,273
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	399,590	783,564
4	Supply Inventory (priced at LCM)	42,732	42,732
5	Short-Term Investments		
6	Prepaid Insurance		
7	Other Prepaid Expenses	1,130	1,130
8	Accounts Receivable (owners or related parties)		
9	Other(specify):		
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,096,655	\$ 1,978,798
B. Long-Term Assets			
11	Long-Term Notes Receivable		
12	Long-Term Investments		
13	Land	35,000	35,000
14	Buildings, at Historical Cost	3,993,945	3,993,945
15	Leasehold Improvements, at Historical Cost		
16	Equipment, at Historical Cost	966,811	966,811
17	Accumulated Depreciation (book methods)	(3,706,566)	(3,706,566)
18	Deferred Charges		
19	Organization & Pre-Operating Costs		
20	Accumulated Amortization - Organization & Pre-Operating Costs		
21	Restricted Funds		
22	Other Long-Term Assets (specify):		
23	Other(specify):		
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,289,190	\$ 1,289,190
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,385,845	\$ 3,267,988

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 197,711	\$ 203,829
27	Officer's Accounts Payable		
28	Accounts Payable-Patient Deposits		
29	Short-Term Notes Payable		
30	Accrued Salaries Payable	116,883	116,883
31	Accrued Taxes Payable (excluding real estate taxes)		
32	Accrued Real Estate Taxes(Sch.IX-B)		
33	Accrued Interest Payable		
34	Deferred Compensation		
35	Federal and State Income Taxes		
Other Current Liabilities(specify):			
36	Employee Benefits	280,235	280,235
37	Resident Refunds		6,273
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 594,829	\$ 607,220
D. Long-Term Liabilities			
39	Long-Term Notes Payable		
40	Mortgage Payable		
41	Bonds Payable		
42	Deferred Compensation		
Other Long-Term Liabilities(specify):			
43			
44			
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 594,829	\$ 607,220
47	TOTAL EQUITY(page 18, line 24)	\$ 1,791,016	\$ 2,660,768
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,385,845	\$ 3,267,988

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,217,551	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,217,551	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	573,465	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 573,465	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,791,016	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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

0020255

Report Period Beginning: **12-01-06**

Ending:

11-30-07

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,263,170	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,263,170	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	1,294	5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,294	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,280	11
12	Gift and Coffee Shop	254	12
13	Barber and Beauty Care	2,506	13
14	Non-Patient Meals	136,820	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	2,182	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)	\$ 143,042	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,338	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,338	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See attached Schedule</u>	1,323,179	28
28a	<u>Interfund Transfers</u>	(293,604)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,029,575	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,442,419	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,257,405	31
32	Health Care	2,909,106	32
33	General Administration	1,139,863	33
B. Capital Expense			
34	Ownership	129,075	34
C. Ancillary Expense			
35	Special Cost Centers	1,433,505	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,868,954	40
41	Income before Income Taxes (line 30 minus line 40)**	573,465	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 573,465	43

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

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

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

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

Facility Name & ID Number **Platt County Nursing Home**

0020255

Report Period Beginning: 12-01-06

Ending: 11-30-07

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	1,562	2,007	\$ 55,485	\$ 27.65	1
2	Assistant Director of Nursing	1,581	1,902	47,226	24.83	2
3	Registered Nurses	19,876	21,864	515,683	23.59	3
4	Licensed Practical Nurses	12,503	14,059	295,528	21.02	4
5	CNAs & Orderlies	77,006	83,155	1,004,680	12.08	5
6	CNA Trainees	273	273	3,007	11.01	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	349	349	5,043	14.45	9
10	Activity Assistants	8,943	10,382	110,120	10.61	10
11	Social Service Workers	2,683	3,112	36,990	11.89	11
12	Dietician					12
13	Food Service Supervisor	1,927	2,176	43,633	20.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,169	34,102	339,917	9.97	15
16	Dishwashers					16
17	Maintenance Workers	8,814	10,212	133,603	13.08	17
18	Housekeepers	10,182	11,178	114,800	10.27	18
19	Laundry	3,146	3,456	31,089	9.00	19
20	Administrator	1,905	2,168	63,194	29.15	20
21	Assistant Administrator					21
22	Other Administrative	8,335	9,677	150,827	15.59	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)	449	449	11,304	25.18	32
33	Other(specify)	8,320	9,624	110,380	11.47	33
34	TOTAL (lines 1 - 33)	199,023	220,145	\$ 3,072,509 *	\$ 13.96	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	2,385	\$ 100,245	50
51	Licensed Practical Nurses	1,143	37,891	51
52	Certified Nurse Assistants/Aides	1,130	225,165	52
53	TOTAL (lines 50 - 52)	4,658	\$ 363,301	53

Facility Name & ID Number Piatt County Nursing Home# 0020255Report Period Beginning: 12-01-06Ending: 11-30-07**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 \$100.00, LSN \$4725.00, CNHA \$930.00
- (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? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,658 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. \$ 54,813
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. \$ 17,909
- (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. \$ _____
- 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: May, Cocagne, & King 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 Scehdule V - Reallocation	Nursing	Social Service	Activities	Volunteers	Dietary	Maintenance	Housekeeping	Admin	Nursing Transport	Faith In Action	Employee Benefits	Medical Transport	Plant Operations
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	31	-2915	0	361	0	0	0
Total	10809	1197	329	4	1636	730	310	-15375	0	361	0	0	0
Line #	10	12	11	15	1	6	3	21	14	43	22	38	6

PCNH
Income Statement
30-Nov-07

Schedule XVII, Line 28, Other Revenue

Medical Records Fees	\$311.00
NA Training Contractual Recovery	\$60.00
Purchase Rebates	\$1,295.00
Write Off AR	-\$578.00
Gain/Loss - Sale of Assets	-\$1,671.00
Foundation Contribution	\$186,140.00
PCSS Income	\$57,145.00
FIA Income	\$37,910.00
Transfers from County	\$810,567.00
Property Tax Levy	\$232,000.00
	\$1,323,179.00

**PCNH 2007
Cost Center Expenses
Supporting Schedules**

Schedule V, Line 7, General Services

Materials Management

Salaries	9525
Other Expense	2198
Other Supplies	87
	<u>11810</u>

Schedule V, Line 15, Health Care Programs

Volunteer Program Coordinator

Salaries & Wages	18011
Courtesy Cart Supplies	260
Other Supplies	279
Staff Development	152
Service on Demand	17
Travel	18
	<u>18736</u>

Schedule V, Line 43, Special Cost Centers

Piatt County Services for Seniors

Salaries & Wages	43028
Telephone Expense	1665
Postage Expense	592
Copier Expense	141
Supplies	1355
Secretarial Expense	2400
Rental Expense	1825
Staff Development/Travel	4084
Equipment	1075
	<u>56166</u>

Piatt 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

Marketing Expense	470
Salaries & Wages	21625
Telephone	849
Postage	1145
Copier Expense	585
Supplies	1238
Volunteer Rec. & Training	1125
Dues & Fees	150
Staff Development	35
Rent	1590
Travel	722
Equipment & Repair	894
Fundraising	390
	<u>30817</u>

Piatt 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

Insurance Expense	397
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This property expense is incurred on PCNH Foundation property. All expenses for this agency have been eliminated on Schedule V, Line 43.

Intergovernmental Transfers	1291782
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Piatt County Nursing Home is a participant in Illinois Funds. This amount has been eliminated on Schedule V, Line 42.

PCNH
Support Schedule
30-Nov-07

Schedule XIV, Section G, Schedule of Travel and Seminar

K. Bradley, Executive Director
Standing Ovations - Creating a Recruitment & Recognition Culture
AAHSA, Audio Conference, 2/21/07

K. Bradley, Executive Director
Supportive Living Success
Illinois Education Association, Springfield, IL 6/14/07

K. Bradley, Executive Director
The New Standards for F253, Accidents and Supervision
IHCA, Springfield, IL 8/29/07

K. Bradley, Executive Director
Work Ethics Training
Richard Lake, 8/17/07

K. Bradley, Executive Director
CNHA of Illinois Annual Meeting
CNHA of Illinois, Peoria, IL 9/25/07 - 9/26/07

K. Bradley, Executive Director
2007 Senior Living Conference
LSN, Lisle, IL 10/02/07 & 10/03/07

K. Bradley, Executive Director
Supportive Living Success
LSN, Springfield, IL 11/27/07

S. Craig, Personnel Director
Standing Ovations - Creating a Recruitment & Recognition Culture
AAHSA, Audio Conference, 2/21/07

S. Craig, Personnel Director
The Role of the Human Resource Assistant
Employers Association, Peoria, IL 3/29/07

S. Craig, Personnel Director
Becoming a People Place - 2007 Human Resource Symposium
LSN, Utica, IL 9/5/07

R. Clarkson, Personnel Coordinator
Standing Ovations - Creating a Recruitment & Recognition Culture
AAHSA, Audio Conference, 2/21/07

R. Clarkson, Personnel Coordinator
The Role of the Human Resource Assistant
Employers Association, Peoria, IL 3/29/07

R. Clarkson, Personnel Coordinator
Annual Employment Law Update
Employers Association, Peoria, IL 9/12/07