

Facility Name & ID Number Piatt County Nursing Home

0020255 Report Period Beginning: 12/01/07 Ending: 11/30/08

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	36,600	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	36,600	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	441	1,043		1,484	8
9	SNF/PED					9
10	ICF	16,194	17,680		33,874	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,635	18,723		35,358	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.61%

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, Kirby Hospital patient meals, 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 12/01/1973

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 100 and days of care provided _____

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/07 Ending: 11/30/08

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	406,832	31,824	12,705	451,361	1,916	453,277	(337)	452,940		1
2	Food Purchase		286,955		286,955		286,955	(237,524)	49,431		2
3	Housekeeping	118,731	12,778	113	131,622	2	131,624		131,624		3
4	Laundry	31,489	12,301	130,712	174,502		174,502		174,502		4
5	Heat and Other Utilities			140,738	140,738		140,738		140,738		5
6	Maintenance	125,521	14,613	37,740	177,874	735	178,609		178,609		6
7	Other (specify):*	8,935	456	2,286	11,677		11,677	(2,269)	9,408		7
8	TOTAL General Services	691,508	358,927	324,294	1,374,729	2,653	1,377,382	(240,130)	1,137,252		8
	B. Health Care and Programs										
9	Medical Director			1,160	1,160		1,160		1,160		9
10	Nursing and Medical Records	2,025,189	332,416	435,745	2,793,350	11,116	2,804,466		2,804,466		10
10a	Therapy		9	111,064	111,073		111,073		111,073		10a
11	Activities	114,521	2,825	1,772	119,118	397	119,515		119,515		11
12	Social Services	38,540	620	2,656	41,816	1,181	42,997		42,997		12
13	CNA Training	12,404	60	1,932	14,396		14,396		14,396		13
14	Program Transportation			811	811		811		811		14
15	Other (specify):*	18,313	639	171	19,123		19,123	(7)	19,116		15
16	TOTAL Health Care and Programs	2,208,967	336,569	555,311	3,100,847	12,694	3,113,541	(7)	3,113,534		16
	C. General Administration										
17	Administrative	66,767			66,767		66,767		66,767		17
18	Directors Fees							5,419	5,419		18
19	Professional Services			10,000	10,000		10,000		10,000		19
20	Dues, Fees, Subscriptions & Promotions			21,268	21,268		21,268	(1,107)	20,161		20
21	Clerical & General Office Expenses	161,486	16,800	52,228	230,514	(15,389)	215,125	(87,784)	127,341		21
22	Employee Benefits & Payroll Taxes			824,643	824,643		824,643		824,643		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,605	3,605		3,605		3,605		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	228,253	16,800	928,344	1,173,397	(15,389)	1,158,008	(83,472)	1,074,536		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,128,728	712,296	1,807,949	5,648,973	(42)	5,648,931	(323,609)	5,325,322		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

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Report Period Beginning:

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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			126,331	126,331		126,331		126,331		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							(8,278)	(8,278)		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			129,811	129,811		129,811	(8,278)	121,533		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			803,948	803,948		803,948	(749,198)	54,750		42
43	Other (specify):* FIA, PCSS	64,586	4,297	29,207	98,090	42	98,132	(102,384)	(4,252)		43
44	TOTAL Special Cost Centers	64,586	4,297	833,155	902,038	42	902,080	(851,582)	50,498		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,193,314	716,593	2,770,915	6,680,822		6,680,822	(1,183,469)	5,497,353		45

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

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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				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(237,524)	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	(8,278)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,269)	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	(1,107)	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 See attached	(940,316)	3, 15, 21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,189,494)		\$	30

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)	6,025	Cty Emp	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,025		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,183,469)		37

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

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

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

BHF USE ONLY					
48		49		50	51
					52

Piatt County Nursing Home

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Diet Supplies	\$ (337)	1	1
2	Volunteer Expense	(7)	15	2
3	PCSS, FIA, Baer	(102,384)	43	3
4	Operating Income - Foundation Reimbursement	(88,390)	21	4
5	IGT	(749,198)	42	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(940,316)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Piatt County Nursing Home

0020255

Report Period Beginning:

12/01/07

Ending:

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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	(337)	0	0	0	0	0	0	0	0	0	0	(337)	1
2	Food Purchase	(237,524)	0	0	0	0	0	0	0	0	0	0	(237,524)	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):*	(2,269)	0	0	0	0	0	0	0	0	0	0	(2,269)	7
8	TOTAL General Services	(240,130)	0	0	0	0	0	0	0	0	0	0	(240,130)	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	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(7)	0	0	0	0	0	0	0	0	0	0	(7)	15
16	TOTAL Health Care and Programs	(7)	0	0	0	0	0	0	0	0	0	0	(7)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	5,419	0	0	0	0	0	0	0	0	0	5,419	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,107)	0	0	0	0	0	0	0	0	0	0	(1,107)	20
21	Clerical & General Office Expenses	(88,390)	606	0	0	0	0	0	0	0	0	0	(87,784)	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	(89,497)	6,025	0	(83,472)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(329,634)	6,025	0	(323,609)	29								

STATE OF ILLINOIS

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Summary B

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,278)	0	0	0	0	0	0	0	0	0	0	(8,278)	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	(8,278)	0	0	0	0	0	0	0	0	0	0	(8,278)	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	(749,198)	0	0	0	0	0	0	0	0	0	0	(749,198)	42
43	Other (specify):*	(102,384)	0	0	0	0	0	0	0	0	0	0	(102,384)	43
44	TOTAL Special Cost Centers	(851,582)	0	0	0	0	0	0	0	0	0	0	(851,582)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,189,494)	6,025	0	(1,183,469)	45								

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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: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V	18 Nursing Home Committee	\$		100.00%	\$ 5,419	\$ 5,419 1
2	V	21 IMRF/FICA		County Clerks Office	100.00%	287	287 2
3	V	Health Insurance Reports					3
4	V	Fed & IL Inc. Tax					4
5	V	21 Reconciling Bank Statements		County Treasurer	100.00%	319	319 5
6	V	Recording checks AP & PR					6
7	V	Check Signing, Funded Depr.					7
8	V						8
9	V						9
10	V						10
11	V					221,044	11
12	V	22 IMRF/FICA				209,208	12
13	V	22 Unemp Comp & Health Insurance					13
14	Total		\$			\$ 436,277	\$ * 6,025 14

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

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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.

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

Facility Name & ID Number

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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	Name of Lender	2		3	4	5	6		8	9	10						
		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							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$						

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2008 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:				
2003	_____	8		
2004	_____	9		
2005	_____	10		
2006	_____	11		
2007	_____	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

12/01/07 Ending:

11/30/08

X. BUILDING AND GENERAL INFORMATION:

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1973	1970	\$ 800,000	\$	30	\$	\$	\$ 800,000	4
5	36		1975	1974	525,102		30			525,102	5
6	4		1989	1989	863,408	28,801	30	28,801		561,238	6
7	Bldg Proj		1993	1993	244,299	8,143	30	8,143		126,227	7
8											8
Improvement Type**											
9	Building Project			1976	7,130		20			7,130	9
10	Building Project			1977	8,236		20			8,236	10
11	Building Project			1978	541		20			541	11
12	Building Project			1979	4,254		20			4,254	12
13	Building Project			1980	170,832		20			170,832	13
14	Building Project			1981	6,276		20			6,276	14
15	Building Project			1982	6,960		20			6,960	15
16	Building Project			1983	56,871		20			56,871	16
17	Building Project			1984	1,490		5			1,490	17
18	Building Project			1984	1,831		10			1,831	18
19	Building Project			1984	7,260		20			7,260	19
20	Building Project			1985	962		5			962	20
21	Building Project			1985	18,315		20			18,315	21
22	Building Project			1986	6,415		10			6,415	22
23	Building Project			1986	5,472		20			5,472	23
24	Building Project			1987	7,987		5			7,987	24
25	Building Project			1987	3,597		10			3,597	25
26	Building Project			1987	1,000		15			1,000	26
27	Building Project			1987	1,509		20			1,509	27
28	Building Project			1988	5,395		5			5,395	28
29	Building Project			1988	22,150		15			22,150	29
30	Building Project			1988	22,737	567	20	567		22,737	30
31	Building Project			1989	72,494		15			72,494	31
32	Building Project			1989	18,169		5			18,169	32
33	Building Project			1990	13,836		15			13,836	33
34	Building Project			1991	1,120		5			1,120	34
35	Building Project			1991	2,890		10			2,890	35
36	Building Project			1991	44,194		15			44,194	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Piatt County Nursing Home

0020255

Report Period Beginning:

12/01/07

Ending:

11/30/08

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 h	1996	7,582		10			7,582	41
42	Bldg Imp: New Pipes & New Roof	1997	227,748	11,388	20	11,388		130,955	42
43	Bldg Imp: New Water Heater	1998	5,377	358	15	358		3,763	43
44	Bldg Imp: Patient Rooms & Halls; Water Heater Installs	1998	4,046	200	20	200		2,124	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		40,480	46
47	Bldg Imp: Telephone Wiring; Handicap door; Carrier Units	2000	13,585	1,359	10	1,359		12,226	47
48	Bldg Imp: Patient Overbed Lights; Dining Room	2000	23,373	1,558	10	1,558		14,023	48
49	Bldg Imp: Resident Room & Common Area Remodeling	2001	46,868	4,687	10	4,687		37,496	49
50	Bldg Imp: Carrier Units	2001	3,080	205	15	205		1,643	50
51	Bldg Imp: Garage & Feasibility	2002	4,588	459	10	459		2,983	51
52	Bldg Imp: Overbed Lights; Closet Doors; convectors	2002	21,597	1,440	15	1,440		9,360	52
53	Bldg Imp: Tile work in shower rooms	2002	2,267	113	20	113		737	53
54	Bldg Imp: Sprinkler Work	2003	9,840	394	8	394		2,165	54
55	Bldg Imp: Halcyon kitchen; beauty shop; admin roof, entry door	2004	13,838	1,384	10	1,384		6,228	55
56	Bldg Imp: Halcyon Awning & Convectors	2004	5,108	341	15	341		1,533	56
57	Bldg Imp: Shower Repair	2004	985	49	20	49		222	57
58	Bldg Imp: Act Office Remodel; Paint & Tile; Motor for Boiler	2005	676	68	10	68		237	58
59	Bldg Imp: Air Cond 1st & 2nd Stage Compressors	2005	12,416	828	15	828		2,897	59
60	Bldg Imp: Nurse Call System; Fire Wall Work	2006	68,545	6,855	10	6,855		17,136	60
61	Bldg Imp: Concrete Sidewalk	2006	5,695	380	15	380		949	61
62	Bldg Imp: Sewer Replacment & Repair	2006	7,193	288	25	288		719	62
63	Bldg Imp: Admin Carpet	2007	2,552	510	5	510		510	63
64	Bldg Imp: Dining & Kitchen Roof; Oasis Flooring	2007	8,265	1,181	7	1,181		1,181	64
65	Bldg Imp: Nook & 40's Hall remodel; LR Furnace; water heater; ligh	2008	64,282	3,214	10	3,214		3,214	65
66	Bldg Imp: Mop Sink	2008	895	22	20	22		22	66
67	Bldg Imp: Sprinkler System Upgrade	2008	3,288	66	25	66		66	67
68	Grounds Imp	1976	954		10			954	68
69	Grounds Imp	1977	2,298		10			2,298	69
70	TOTAL (lines 4 thru 69)		\$ 3,662,740	\$ 79,119		\$ 79,119	\$	\$ 2,894,039	70

**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:

12/01/07

Ending:

11/30/08

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		\$ 3,662,740	\$ 79,119		\$ 79,119	\$	\$ 2,894,039	1
2	Grounds Improvement	1978	1,729		10			1,729	2
3	Grounds Improvement	1979	6,235		10			6,235	3
4	Grounds Improvement	1980	3,031		10			3,031	4
5	Grounds Improvement	1981	2,803		10			2,803	5
6	Grounds Improvement	1982	1,196		10			1,196	6
7	Grounds Improvement	1983	1,212		12			1,212	7
8	Grounds Improvement	1984	7,796		10			7,796	8
9	Grounds Improvement	1986	1,077		10			1,077	9
10	Grounds Improvement	1987	6,713		3			6,713	10
11	Grounds Improvement	1987	1,118		10			1,118	11
12	Grounds Improvement	1989	11,701		10			11,701	12
13	Grounds Improvement	1990	2,682		10			2,682	13
14	Grounds Improvement	1992	51,409		10			51,409	14
15	Grounds Improvement	1993	4,988		10			4,988	15
16	Grnds Imp: New front/rear sign; restripe lot	1996	9,884		10			9,884	16
17	Grnds Imp: Tree removal & excavation	1998	8,691						17
18	Grnds Imp: ARD Awning; Truck Turnaround; sidewalk	1998	6,461	324	10	324		6,461	18
19	Grnds Imp: Tile Repair	1999	765	77	10	77		728	19
20	Grnds Imp: Concrete Patio	2000	2,107	211	10	211		1,896	20
21	Grnds Imp: Landscaping	2001	1,850		5			1,850	21
22	Grnds Imp: Surfacing;Striping & Patching of Parking Lot	2003	14,884	1,861	8	1,861		10,235	22
23	GASB 34 Adj in 2004	2004	(16,641)					(16,641)	23
24	Grnds Imp: Drive Resurfacing	2007	1,300	87	5	87		130	24
25	Grnds Imp: Fence	2008	6,460	213	15	213		213	25
26	Grnds Imp: Smoking Hut	2008	2,637	65	20	65		65	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,804,828	\$ 81,957		\$ 81,957	\$	\$ 3,012,550	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: 12/01/07 Ending: 11/30/08

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	\$ 393,228	\$ 42,061	\$ 42,061	\$		\$ 243,226	71
72	Current Year Purchases	10,950	548	548			548	72
73	Fully Depreciated Assets	567,512	1,764	1,764			570,826	73
74								74
75	TOTALS	\$ 971,690	\$ 44,373	\$ 44,373	\$		\$ 814,600	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)	\$ 4,811,518	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 126,330	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 126,330	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)	\$ 3,827,150	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	Assisted Living Fees	\$ 3,888,522	92
93			93
94			94
95		\$ 3,888,522	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			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$ 60	\$ 120	\$	\$ 180
2	Books and Supplies	26	118		144
3	Classroom Wages (a)	2,246	6,865		9,110
4	Clinical Wages (b)		3,294		3,294
5	In-House Trainer Wages (c)				
6	Transportation	188	1,250		1,438
7	Contractual Payments				
8	CNA Competency Tests		230		230
9	TOTALS	\$ 2,519	\$ 11,877	\$	\$ 14,396
10	SUM OF line 9, col. 1 and 2 (e)	\$ 14,396			

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	6

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	2,243	\$ 44,834	\$	2,243	\$ 44,834	1
2	Licensed Speech and Language Development Therapist		hrs		249	7,467		249	7,467	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,935	58,763		2,935	58,763	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				137,475		137,475	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	5,427	\$ 111,064	\$ 137,475	5,427	\$ 248,539	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.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/07 Ending: 11/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/08 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,156,639	\$ 1,902,472	1
2	Cash-Patient Deposits		5,921	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	630,564	1,014,538	3
4	Supply Inventory (priced at)	41,157	41,157	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,130	1,130	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,829,490	\$ 2,965,218	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,000	35,000	13
14	Buildings, at Historical Cost	7,693,350	7,693,350	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	971,690	971,690	16
17	Accumulated Depreciation (book methods)	(3,827,151)	(3,827,151)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,872,889	\$ 4,872,889	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,702,379	\$ 7,838,107	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 669,105	\$ 716,875	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	137,646	137,646	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	10,411	10,411	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Employee Benefits</u>	276,625	276,625	36
37	<u>Resident Refunds</u>		5,921	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,093,787	\$ 1,147,478	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,000,000	2,000,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>General Obligation Debt Certificates</u>	1,255,000	1,255,000	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,255,000	\$ 3,255,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,348,787	\$ 4,402,478	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,353,592	\$ 3,435,629	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,702,379	\$ 7,838,107	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,851,175	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,851,175	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	502,417	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)	\$ 502,417	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,353,592	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Piatt County Nursing Home

0020255

Report Period Beginning: 12/01/07

Ending: 11/30/08

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	\$ 5,997,732	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,997,732	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	2,436	5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,436	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,024	11
12	Gift and Coffee Shop	342	12
13	Barber and Beauty Care	2,248	13
14	Non-Patient Meals	149,118	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	2,250	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)	\$ 154,982	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	19,450	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,450	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See attached schedule</u>	1,212,854	28
28a	<u>Interfund Transfers</u>	(206,040)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,006,814	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,181,414	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,372,904	31
32	Health Care	3,100,847	32
33	General Administration	1,173,397	33
B. Capital Expense			
34	Ownership	129,811	34
C. Ancillary Expense			
35	Special Cost Centers	902,038	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)*	\$ 6,678,997	40
41	Income before Income Taxes (line 30 minus line 40)**	502,417	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 502,417	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 Piatt County Nursing Home

0020255

Report Period Beginning:

12/01/07

Ending:

11/30/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,056	2,517	\$ 66,154	\$ 26.28	1
2	Assistant Director of Nursing	1,764	2,224	56,540	25.42	2
3	Registered Nurses	18,923	20,937	502,373	23.99	3
4	Licensed Practical Nurses	12,982	14,676	322,265	21.96	4
5	CNAs & Orderlies	77,354	82,590	1,050,077	12.71	5
6	CNA Trainees	1,103	1,103	12,044	10.92	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	335	335	5,018	14.98	9
10	Activity Assistants	8,921	10,152	19,503	1.92	10
11	Social Service Workers	2,622	3,124	38,540	12.34	11
12	Dietician					12
13	Food Service Supervisor	1,922	2,412	49,930	20.70	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,530	33,886	356,903	10.53	15
16	Dishwashers					16
17	Maintenance Workers	9,427	10,188	134,456	13.20	17
18	Housekeepers	10,007	10,998	118,731	10.80	18
19	Laundry	3,220	3,360	31,489	9.37	19
20	Administrator	1,877	2,185	66,767	30.56	20
21	Assistant Administrator					21
22	Other Administrative	8,119	9,677	161,487	16.69	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>PCSS, FIA</u>	8,548	9,973	114,199	11.45	33
34	TOTAL (lines 1 - 33)	190,710	220,337	\$ 3,106,476 *	\$ 14.10	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	2,129	\$ 92,263		50
51	Licensed Practical Nurses	938	31,727		51
52	Certified Nurse Assistants/Aides	13,906	284,833		52
53	TOTAL (lines 50 - 52)	16,973	\$ 408,823		53

Facility Name & ID Number Piatt County Nursing Home

0020255

Report Period Beginning: 12/01/07

Ending: 11/30/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Karla Bradley	Executive director	0	\$ 66,767	Workers' Compensation Insurance	\$ 60,000	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	23,296	Advertising: Employee Recruitment	9,795		
				FICA Taxes	236,963	Health Care Worker Background Check			
				Employee Health Insurance	268,913	(Indicate # of checks performed <u>39</u>)	390		
				Employee Meals	19,201	Patient Background Checks <u>48</u>	480		
				Illinois Municipal Retirement Fund (IMRF)*	221,044	LSN	5,255		
				Employee Awards & Assistance Program	11,306	CNHA of Illinois	980		
				Medical Expense - Physicals	3,171	INHAA	100		
						Employers Association	466		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 66,767			Less: Public Relations Expense	()		
(List each licensed administrator separately.)						Non-allowable advertising	()		
						Yellow page advertising	()		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,456		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 843,894		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
B. Administrative - Other				Description	Line #	Amount	G. Schedule of Travel and Seminar**		
Description			Amount				Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel	954	
							Seminar Expense	2,651	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL	\$ 3,605
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 10,000						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Piatt County Nursing Home

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 \$5255, 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? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,241 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. \$ 19,201
- (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? es - Draft 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 - Reallocation	Nursing	Social Service	Activities	Dietary	Maintenance	Housekeeping	Admin	Faith In Action
Transportation Medical Purposes Resident	0	0	0	0	0	0	0	
Admin - Clerical	6610	0	200	768	0	0	-7578	
Telephone Expense	295	836	0	836	715	0	-5372	
Copier Expense	1521	345	197	312	20	2	-2439	42
	<u>8426</u>	<u>1181</u>	<u>397</u>	<u>1916</u>	<u>735</u>	<u>2</u>	<u>-15389</u>	<u>42</u>
Line #	10	12	11	1	6	3	21	43

PCNH 2008
Cost Center Expenses
Supporting Schedules

Schedule V, Line 7, Genreal Services

Materials Management

Salaries	8935
Other Expense	23025
Other Supplies	441
	<u>32401</u>

Schedule V, Line 15, Health Care Programs

Volunteer Program Coordinator

Salaries	18310
Other Expense	259
Other Supplies	380
Staff Development	49
Service on Demand	105
Travel	17
	<u>19120</u>

Section V, Line 43 - Special Cost Centers

Piatt County Services for Seniors

Salaries & Wages	40492
Telephone Expense	1652
Postage Expense	181
Copier Expense	1169
Supplies	838
Secretarial Service	2400
Rental Expense	2100
Staff Development/Travel	840
Equipment	4234
Pamphlets/Non-Grant Related/Grant Payback	816
	<u>54722</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

Salaries & Wages	27617
Telephone	852
Postage	1479
Copier Expense	1
Supplies	629
Pamphlets	0
Volunteer Recognition & Training	460
Insurance Expense - Dues & Fees	50
Staff Development	989
Rental Expense	1800
Travel	2060
Equipment & Repair	0
Fundraising	11725
	<u>47662</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.

Intergovernmental Transfers 749198

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

PCNH
Income Statement
30-Nov-08

Schedule XVII, Line 28, Other Revenue

Medical Records Fees	17
NA Training Contractual Recovery	138
Purchase Rebates	2269
Write Off AR	-5341
Gain/Loss Sale of Assets	311
Foundation Contribution	216287
PCSS Income	48363
FIA Income	47204
Transfers from County	810216
Property Tax Levy	315658
Manpower Reimbursement	721
Supportive Living Interest	-66131
County Contribution	-157500
Exchange Account	642
	1212854