

Facility Name & ID Number SCOTT COUNTY NURSING CENTER

0004234 Report Period Beginning: 12/01/08 Ending: 11/30/09

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,934	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	49	TOTALS	49	17,934	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			1,283	1,283	8
9	SNF/PED					9
10	ICF	8,850	6,188		15,038	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,850	6,188	1,283	16,321	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.01%

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

0 (Do not include bed-hold days in Section B.)

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

DAY CARE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 04/19/1971

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 49 and days of care provided 1,283

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: N/A Fiscal Year: 11/30

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

Facility Name & ID Number **SCOTT COUNTY NURSING CENTER** # **0004234** Report Period Beginning: **12/01/08** Ending: **11/30/09**

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	147,333	7,938	4,320	159,591		159,591		159,591		1
2	Food Purchase		94,634		94,634		94,634	(382)	94,252		2
3	Housekeeping	142,005	12,805		154,810		154,810		154,810		3
4	Laundry	33,387	7,822		41,209		41,209		41,209		4
5	Heat and Other Utilities			73,914	73,914		73,914		73,914		5
6	Maintenance	29,823	28,184	62,438	120,445		120,445		120,445		6
7	Other (specify):*										7
8	TOTAL General Services	352,548	151,383	140,672	644,603		644,603	(382)	644,221		8
	B. Health Care and Programs										
9	Medical Director			7,575	7,575		7,575		7,575		9
10	Nursing and Medical Records	965,230	146,723	97,747	1,209,700		1,209,700	(7,721)	1,201,979		10
10a	Therapy										10a
11	Activities	52,194	6,100	566	58,860		58,860		58,860		11
12	Social Services	23,026			23,026		23,026		23,026		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,040,450	152,823	105,888	1,299,161		1,299,161	(7,721)	1,291,440		16
	C. General Administration										
17	Administrative	49,920	12,194	1,154	63,268		63,268		63,268		17
18	Directors Fees										18
19	Professional Services			19,301	19,301		19,301		19,301		19
20	Dues, Fees, Subscriptions & Promotions			2,787	2,787		2,787		2,787		20
21	Clerical & General Office Expenses	33,842			33,842		33,842	5,788	39,630		21
22	Employee Benefits & Payroll Taxes			112,135	112,135		112,135	134,442	246,577		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,840	6,840		6,840		6,840		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			200	200		200	13,788	13,988		26
27	Other (specify):*										27
28	TOTAL General Administration	83,762	12,194	142,417	238,373		238,373	154,018	392,391		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,476,760	316,400	388,977	2,182,137		2,182,137	145,915	2,328,052		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 **SCOTT COUNTY NURSING CENTER**

#0004234

Report Period Beginning:

12/01/08

Ending:

11/30/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			56,616	56,616		56,616		56,616			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			56,616	56,616		56,616		56,616			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			499,279	499,279		499,279		499,279			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			499,279	499,279		499,279		499,279			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,476,760	316,400	944,872	2,738,032		2,738,032	145,915	2,883,947			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (6,975)	10	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(382)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(746)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,103)		\$	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)	154,018		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 154,018		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 145,915		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

SCOTT COUNTY NURSING CENTER

ID# 0004234

Report Period Beginning: 12/01/08

Ending: 11/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SCOTT COUNTY NURSING CENTER# 0004234

Report Period Beginning:

12/01/08

Ending:

11/30/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(382)	0	0	0	0	0	0	0	0	0	0	(382)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(382)	0	0	0	0	0	0	0	0	0	0	(382)	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	(7,721)	0	0	0	0	0	0	0	0	0	0	(7,721)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(7,721)	0	0	0	0	0	0	0	0	0	0	(7,721)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	5,788	0	0	0	0	0	0	0	0	0	5,788	21
22	Employee Benefits & Payroll Taxes	0	134,442	0	0	0	0	0	0	0	0	0	134,442	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	13,788	0	0	0	0	0	0	0	0	0	13,788	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	154,018	0	154,018	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,103)	154,018	0	145,915	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SCOTT COUNTY NURSING CENTER

0004234

Report Period Beginning:

12/01/08

Ending:

11/30/09

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 TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(8,103)	154,018	0	0	0	0	0	0	0	0	0	145,915	45

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	21 CLERICAL	\$	SCOTT COUNTY	100.00%	\$ 5,788	\$ 5,788	1
2	V	22 IMRF		SCOTT COUNTY	100.00%	90,738	90,738	2
3	V	22 WORKMAN'S COMPENSATION		SCOTT COUNTY	100.00%	36,015	36,015	3
4	V	22 UNEMPLOYMENT		SCOTT COUNTY	100.00%	7,689	7,689	4
5	V	26 INSURANCE		SCOTT COUNTY	100.00%	13,788	13,788	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 154,018	\$ * 154,018	14

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

Facility Name & ID Number **SCOTT COUNTY NURSING CENTER** # **0004234** Report Period Beginning: **12/01/08** Ending: **11/30/09**

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER

0004234

Report Period Beginning:

12/01/08

Ending: 11/30/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization SCOTT COUNTY
 Street Address COURT HOUSE
 City / State / Zip Code WINCHESTER, IL 62694
 Phone Number (217-742-3368
 Fax Number (217-742-5853

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	BOOKKEEPING	HOURS	2,080	2	\$ 28,938	\$ 24,672	416	\$ 5,788	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					\$ 28,938	\$ 24,672		\$ 5,788	25

Facility Name & ID Number

SCOTT COUNTY NURSING CENTER

0004234

Report Period Beginning:

12/01/08

Ending:

11/30/09

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																				
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.)

Facility Name & ID Number SCOTT COUNTY NURSING CENTER

0004234 Report Period Beginning:

12/01/08 Ending:

11/30/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,909 B. General Construction Type: Exterior BRICK Frame CONCRETE Number of Stories ONE

C. Does the Operating Entity? [X] (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? [X] (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).

Empty lines for listing other business entities.

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

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: SITE, 108,909, 1970, \$ 1,567, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 108,909, (blank), \$ 1,567, 3.

Facility Name & ID Number SCOTT COUNTY NURSING CENTER

0004234

Report Period Beginning:

12/01/08

Ending:

11/30/09

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	49	1971	1971	\$ 174,649	\$ 4,356	40	\$ 4,356	\$	\$ 170,214	4
5		1971	1974	1,500		20			1,500	5
6		1974	1974	20,633	558	37	558		20,088	6
7		1974	1974	16,129		VAR			16,129	7
8										8
	Improvement Type**									
9	ENERGY CONTROL		1983	18,678		20			18,678	9
10	WINDOW REMODELING		1986	1,980		20			1,980	10
11	WATER HEATER		1988	5,453		16			5,453	11
12	ELECTRICAL		1989	13,795		20			13,795	12
13	PARKING LOT		1989	3,480		16			3,480	13
14	DOOR EAST SIDE		1989	1,565	5	20	5		1,565	14
15	SPRINKLER SYSTEM		1989	3,150	126	25	126		2,646	15
16	LIGHTS		1990	3,561		10			3,561	16
17	ROOF		1991	57,367		10			57,367	17
18	GARAGE		1991	9,291	465	20	465		8,690	18
19	FOLDING DOOR		1991	1,751		10			1,751	19
20	ELECTRICAL		1992	3,018		10			3,018	20
21	COUNTER TOP		1992	1,920		6			1,920	21
22	BUILDING ADDITION		1993	142,244	4,741	30	4,741		78,227	22
23	PARKING LOT		1993	10,135	323	16	323		10,135	23
24	LAUNDRY		1995	22,174	739	30	739		10,716	24
25	GENERATOR FUEL TANK		1998	4,712	314	15	314		3,611	25
26	ELECTRICAL		1998	1,594		10			1,594	26
27	DINING ROOM		2000	274,460	9,149	30	9,149		86,915	27
28	PATIENT ROOM UPDATE, TILING AND FURNITURE		2000	32,985	3,299	10	3,299		31,340	28
29	FULLY DEPRECIATED FIXED EQUIPMENT		1971	198,138		VAR			198,138	29
30	PATIENT ROOM UPDATE, TILING AND FURNITURE		2001	24,779	2,478	10	2,478		21,063	30
31	SPRINKLER SYSTEM		2001	9,800	392	25	392		3,332	31
32	KITCHEN UPDATE COOLER, VENT		2002	37,053	3,705	10	3,705		27,788	32
33	GENERATOR		2005	13,787	1,379	10	1,379		6,205	33
34	FIRE ALARM UPDATE		2005	28,315	1,416	20	1,416		6,372	34
35										35
36										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 SCOTT COUNTY NURSING CENTER

0004234

Report Period Beginning:

12/01/08

Ending:

11/30/09

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,138,096	\$ 33,445		\$ 33,445	\$	\$ 817,271	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 200,634	\$ 17,196	\$ 17,196	\$	10	\$ 143,559	71
72	Current Year Purchases	9,019	451	451		10	451	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 209,653	\$ 17,647	\$ 17,647	\$		\$ 144,010	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	PROGRAM TRANS	VAN CHEV 2009	2009	\$ 55,243	\$ 5,524	\$ 5,524	\$		\$ 5,524	76
77										77
78										78
79										79
80	TOTALS			\$ 55,243	\$ 5,524	\$ 5,524	\$		\$ 5,524	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)	\$ 1,404,559	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 56,616	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,616	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)	\$ 966,805	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

**Scott County Nursing Center
Equipment Depreciation Schedule
Prior Years' Depreciation
11/30/09**

Year	Cost	Straight Line Depr	Adjustment	Years	Accumulated Depr
1999	57,444	2,876		10	57,444
2000	29,586	2,959		10	28,110
2001	7,839	784		10	6,664
2002	16,382	1,638		10	12,285
2003	12,508	1,251		10	8,131
2004	21,737	2,174		10	11,957
2005	5,892	589		10	2,651
2006	44,645	4,465		10	15,627
2007	-	-		10	-
2008	4,601	460		10	690
	<u>200,634</u>	<u>17,196</u>	<u>-</u>		<u>143,559</u>

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/08 Ending: 11/30/09

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 type="checkbox"/> YES <input checked="" 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 type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **11/30/09**

(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	\$ 808,325	\$ 808,325	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 808,325	\$ 808,325	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,567	1,567	13
14	Buildings, at Historical Cost	1,138,096	1,138,096	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	264,896	264,896	16
17	Accumulated Depreciation (book methods)	(966,805)	(966,805)	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)	\$ 437,754	\$ 437,754	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,246,079	\$ 1,246,079	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO INSURANCE FUND	100,545	100,545	36
37	PAYROLL LIABILITIES	1,119	1,119	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 101,664	\$ 101,664	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	20,020	20,020	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 20,020	\$ 20,020	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 121,684	\$ 121,684	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,124,395	\$ 1,124,395	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,246,079	\$ 1,246,079	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,024,929	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,024,929	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	99,466	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)	\$ 99,466	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)	\$ 1,124,395	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,791,355	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,791,355	3
	B. Ancillary Revenue		
4	Day Care	6,975	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 6,975	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	382	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	746	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)	\$ 1,128	23
	D. Non-Operating Revenue		
24	Contributions	6,681	24
25	Interest and Other Investment Income***	6,359	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13,040	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>FRIENDSHIP GARDEN GRANT</u>	25,000	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,000	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,837,498	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	637,756	31
32	Health Care	1,306,008	32
33	General Administration	238,373	33
	B. Capital Expense		
34	Ownership	56,616	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	499,279	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,738,032	40
41	Income before Income Taxes (line 30 minus line 40)**	99,466	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 99,466	43

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

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

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

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

**Scott County Nursing Center
Required Explanations
Cost Report 2009**

Page 19, Line 25, Column 1

Interest Income

Interest income is not offset to interest expense on Sch V, Line 22, Column 8.

The interest income is not offset because the interest is related to the increase in investments that the Scott County Nursing Center had during FY09. There is no interest expense to offset the interest income because there was no loan/note to pay interest on. The loan payable on the books for Scott County Nursing Center was not payable until FY10.

Page 19, Line 28, Column 1

Friendship Garden Grant

The \$25,000 received as other revenue is not included in Operating income since the grant money cannot be used for anything except expenses for the Friendship Memorial Garden. This grant was received from the Illinois Department of Public Health.

Facility Name & ID Number **SCOTT COUNTY NURSING CENTER**

0004234

Report Period Beginning:

12/01/08

Ending:

11/30/09

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	2,080	2,080	\$ 47,590	\$ 22.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,543	2,822	62,029	21.98	3
4	Licensed Practical Nurses	14,047	19,146	282,421	14.75	4
5	CNAs & Orderlies	42,947	54,111	473,091	8.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,080	2,080	38,210	18.37	8
9	Activity Director	2,080	2,080	24,676	11.86	9
10	Activity Assistants	2,382	2,706	22,815	8.43	10
11	Social Service Workers	2,080	2,080	23,026	11.07	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	32,968	15.85	13
14	Head Cook	5,056	5,812	59,605	10.26	14
15	Cook Helpers/Assistants	6,046	6,207	54,760	8.82	15
16	Dishwashers					16
17	Maintenance Workers	2,685	2,818	29,823	10.58	17
18	Housekeepers	10,620	12,014	142,005	11.82	18
19	Laundry	2,576	2,595	33,387	12.87	19
20	Administrator	2,080	2,080	49,920	24.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	33,842	16.27	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction	529	538	4,703	8.74	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,925	2,099	22,286	10.62	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS Coordinator</u>	2,080	2,080	39,603	19.04	33
34	TOTAL (lines 1 - 33)	107,996	127,508	\$ 1,476,760 *	\$ 11.58	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	96	\$ 4,320	35
36	Medical Director	12	8,250	36
37	Medical Records Consultant	8	156	37
38	Nurse Consultant			38
39	Pharmacist Consultant	12	2,400	39
40	Physical Therapy Consultant	325	17,904	40
41	Occupational Therapy Consultant	243	19,588	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	24	1,516	43
44	Activity Consultant			44
45	Social Service Consultant	4	566	45
46	Other(specify)			46
47	<u>Medicare</u>	27	3,460	47
48	<u>Lab Consultant</u>	45	480	48
49	TOTAL (lines 35 - 48)	796	\$ 58,640	49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
RUBI HOOTS	ADMINISTRATOR	0	\$ 49,920	Workers' Compensation Insurance	\$ 36,015	IDPH License Fee	\$ 2,570	
				Unemployment Compensation Insurance	7,689	Advertising: Employee Recruitment		
				FICA Taxes	112,135	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance		JACKSONVILLE JOURNAL COURIER	217	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*	90,738			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,920					
B. Administrative - Other								
Description			Amount					
KRISTIN OLSON - GRANT WRITER			\$ 1,154			Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,154	TOTAL (agree to Schedule V, line 22, col.8)	\$ 246,577	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,787	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
ZUMBAHLEN, EYTH, SURRATT,	AUDIT		\$ 6,039				Out-of-State Travel	\$
FOOTE & FLYNN, LTD								
							In-State Travel	
LTC SOLUTIONS, INC	TECH SUPPORT		2,100				MILEAGE	855
REVERE HEALTHCARE	MEDICAID AUDIT		9,250				MEALS/HOTEL	1,361
LLOYD VORTMAN								
COMPUTER SERVICE	COMPUTER REPAIR		322				Seminar Expense	
							ADMINISTRATION	4,454
LONGLEY SYSTEMS	SOFTWARE MAINT		399				FOOD SANITATION	170
WATT'S COPY SYSTEMS	MAINTENANCE		1,191					
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 19,301	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6,840

* Attach copy of IMRF notifications

**See instructions.

