



Facility Name & ID Number Piatt County Nursing Home

# 0020255 Report Period Beginning: 12/01/09 Ending: 11/30/10

**III. STATISTICAL DATA**

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

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

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,295	2,295	8
9	SNF/PED					9
10	ICF	17,528	14,990		32,518	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,528	14,990	2,295	34,813	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.38%**

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

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

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

Senior citizen meals, meals for Kirby, Piatt Co. jail meals

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

Yes

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**

YES  NO

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**

YES  NO

**I. On what date did you start providing long term care at this location?**

Date started 12/1/73

**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 2,295

Medicare Intermediary NGS

**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: 12/01/09 Ending: 11/30/10

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclassification 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
	<b>A. General Services</b>										
1	Dietary	428,104	52,270	15,802	496,176		496,176	(54,400)	441,776		1
2	Food Purchase		279,344		279,344		279,344	(30,600)	248,744		2
3	Housekeeping	131,947	21,060	260	153,267		153,267		153,267		3
4	Laundry	36,182	615	126,084	162,881		162,881		162,881		4
5	Heat and Other Utilities			114,541	114,541		114,541		114,541		5
6	Maintenance	155,313	16,298	40,206	211,817		211,817	4,488	216,305		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	751,546	369,587	296,893	1,418,026		1,418,026	(80,512)	1,337,514		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,200	1,200		1,200		1,200		9
10	Nursing and Medical Records	2,284,165	183,473	411,978	2,879,616		2,879,616	(1,912)	2,877,704		10
10a	Therapy			171,461	171,461		171,461		171,461		10a
11	Activities	128,534	4,186	2,065	134,785		134,785		134,785		11
12	Social Services	42,873	667	3,932	47,472		47,472		47,472		12
13	CNA Training	2,694	4	1,290	3,988		3,988		3,988		13
14	Program Transportation										14
15	Other (specify):* <b>Vol. program</b>	20,979	332	528	21,839		21,839		21,839		15
16	<b>TOTAL Health Care and Programs</b>	2,479,245	188,662	592,454	3,260,361		3,260,361	(1,912)	3,258,449		16
	<b>C. General Administration</b>										
17	Administrative	127,494			127,494		127,494	(26,414)	101,080		17
18	Directors Fees										18
19	Professional Services			22,454	22,454		22,454		22,454		19
20	Dues, Fees, Subscriptions & Promotions			16,740	16,740		16,740		16,740		20
21	Clerical & General Office Expenses	114,379	14,676	63,072	192,127	(3,303)	188,824		188,824		21
22	Employee Benefits & Payroll Taxes			917,872	917,872		917,872		917,872		22
23	Inservice Training & Education										23
24	Travel and Seminar					3,303	3,303		3,303		24
25	Other Admin. Staff Transportation			1,179	1,179		1,179		1,179		25
26	Insurance-Prop.Liab.Malpractice			95,000	95,000		95,000		95,000		26
27	Other (specify):* <b>Bad debt</b>			5,795	5,795		5,795	(5,795)			27
28	<b>TOTAL General Administration</b>	241,873	14,676	1,122,112	1,378,661		1,378,661	(32,209)	1,346,452		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,472,664	572,925	2,011,459	6,057,048		6,057,048	(114,633)	5,942,415		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 &amp; ID Number

Piatt County Nursing Home

#0020255

Report Period Beginning:

12/01/09

Ending:

11/30/10

## 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	
	<b>D. Ownership</b>											
30	Depreciation			158,139	158,139		158,139	10,501	168,640			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			3,480	3,480		3,480		3,480			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			161,619	161,619		161,619	10,501	172,120			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,475	18,844	76,319		76,319		76,319			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,900	54,900		54,900		54,900			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		57,475	73,744	131,219		131,219		131,219			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	3,472,664	630,400	2,246,822	6,349,886		6,349,886	(104,132)	6,245,754			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(5,795)	27		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	(98,337)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (104,132)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (104,132)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Piatt County Nursing Home

ID# 0020255

Report Period Beginning: 12/01/09

Ending: 11/30/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Offset expense refunds: Manpower, Jury duty, etc.	\$ (1,912)	10	1
2	Offset expense for Mgt provided to Maple Pt.	(26,414)	17	2
3	Offset expense for non patient meals	(54,400)	1	3
4	Offset expense for non patient meals	(30,600)	2	4
5	Additional depreciation expense	10,501	30	5
6	Reclassify from Bldg to Maint. Items under \$2,500	4,488	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	<b>Total</b>	(98,337)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Piatt County Nursing Home# 0020255

Report Period Beginning:

12/01/09

Ending:

11/30/10

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

	Operating Expenses	PAGES	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	(54,400)	0	0	0	0	0	0	0	0	0	0	(54,400)	1
2	Food Purchase	(30,600)	0	0	0	0	0	0	0	0	0	0	(30,600)	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	4,488	0	0	0	0	0	0	0	0	0	0	4,488	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(80,512)</b>	<b>0</b>	<b>(80,512)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,912)	0	0	0	0	0	0	0	0	0	0	(1,912)	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	<b>TOTAL Health Care and Programs</b>	<b>(1,912)</b>	<b>0</b>	<b>(1,912)</b>	<b>16</b>									
	<b>C. General Administration</b>													
17	Administrative	(26,414)	0	0	0	0	0	0	0	0	0	0	(26,414)	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	0	0	0	0	0	0	0	0	0	0	0	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):*	(5,795)	0	0	0	0	0	0	0	0	0	0	(5,795)	27
28	<b>TOTAL General Administration</b>	<b>(32,209)</b>	<b>0</b>	<b>(32,209)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(114,633)</b>	<b>0</b>	<b>(114,633)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Piatt County Nursing Home

# 0020255

Report Period Beginning:

12/01/09

Ending:

11/30/10

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	10,501	0	0	0	0	0	0	0	0	0	0	10,501	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	<b>TOTAL Ownership</b>	<b>10,501</b>	<b>0</b>	<b>10,501</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(104,132)</b>	<b>0</b>	<b>(104,132)</b>	<b>45</b>									

**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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							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		\$			\$	\$ *	14

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

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/09 Ending: 11/30/10

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Piatt County Nursing Home

# 0020255

Report Period Beginning:

12/01/09

Ending: 11/30/10

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number

Piatt County Nursing Home

# 0020255

Report Period Beginning:

12/01/09

Ending:

11/30/10

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

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1.	Real Estate Tax accrual used on 2009 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 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2005	_____	8	
		2006	_____	9	
		2007	_____	10	
		2008	_____	11	
		2009	_____	12	
<b>FOR BHF USE ONLY</b>					
		13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.**

**2009 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Piatt County Nursing Home COUNTY Piatt

FACILITY IDPH LICENSE NUMBER 0020255

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

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

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

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

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

**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:

12/01/09 Ending:

11/30/10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 37,120 B. General Construction Type: Exterior Brick Frame Comb Number of Stories \_\_\_\_\_

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).

NA

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO

If so, please complete the following:

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>182,592</u>	<u>1972</u>	<u>\$ 35,000</u>	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	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60	1973	1973	\$ 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		618,840	6
7	Bldg Proj	1993	1993	244,299	8,143	30	8,143		142,513	7
8										8
<b>Improvement Type**</b>										
9	Building Improvements		1976	7,130		20			7,130	9
10	Building Improvements		1977	8,236		20			8,236	10
11	Building Improvements		1978	541		20			541	11
12	Building Improvements		1979	4,254		20			4,254	12
13	Building Improvements		1980	170,832		20			170,832	13
14	Building Improvements		1981	6,276		20			6,276	14
15	Building Improvements		1982	6,960		20			6,960	15
16	Building Improvements		1983	56,871		20			56,871	16
17	Building Improvements		1984	1,490		5			1,490	17
18	Building Improvements		1984	1,831		10			1,831	18
19	Building Improvements		1984	7,260		20			7,260	19
20	Building Improvements		1985	962		5			962	20
21	Building Improvements		1985	18,315		20			18,315	21
22	Building Improvements		1986	6,415		10			6,415	22
23	Building Improvements		1986	5,472		20			5,472	23
24	Building Improvements		1987	7,987		5			7,987	24
25	Building Improvements		1987	3,597		10			3,597	25
26	Building Improvements		1987	1,000		15			1,000	26
27	Building Improvements		1987	1,509		20			1,509	27
28	Building Improvements		1988	5,395		5			5,395	28
29	Building Improvements		1988	22,150		15			22,150	29
30	Building Improvements		1988	22,737		20			22,737	30
31	Building Improvements		1989	72,494		15			72,494	31
32	Building Improvements		1989	18,169		5			18,169	32
33	Building Improvements		1990	13,836		15			13,836	33
34	Building Improvements		1991	1,120		5			1,120	34
35	Building Improvements		1991	2,890		10			2,890	35
36	Building Improvements		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:

12/01/09

Ending:

11/30/10

**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	<u>Building Improvement</u>	1992	\$ 5,532	\$	10	\$	\$	\$ 5,532	37
38	<u>Building Improvement</u>	1993	21,036		10			21,036	38
39	<u>Building Improvement</u>	1994	5,888		10			5,888	39
40	<u>Building Improvement</u>	1995	8,381		10			8,381	40
41	<u>Bldg Imp: Admin Office &amp; ARD Remodel; Crash Carts 50's &amp; 60'</u>	1996	7,582		10			7,582	41
42	<u>Bldg Imp: New Pipes &amp; New Roof</u>	1997	227,748	11,388	20	11,388		153,731	42
43	<u>Bldg Imp: New Water Heater</u>	1998	5,377	358	15	358		4,479	43
44	<u>Bldg Imp: Patient Rooms &amp; Halls; Water Heater Installs</u>	1998	4,046	202	20	202		2,528	44
45	<u>Bldg Imp: Security Svstm &amp; Heat Pump</u>	1999	17,009		5			17,009	45
46	<u>Bldg Imp: Kitchen Remodel; Halcyon Roof &amp; Remodel</u>	1999	85,221	4,261	20	4,261		49,002	46
47	<u>Bldg Imp: Telephone &amp; Wiring;Handicap; Carrier Units</u>	2000	13,585		10			13,585	47
48	<u>Bldg Imp: Overbed Lights; Dining Room Remodel</u>	2000	23,373	1,558	10	1,558		17,139	48
49	<u>Bldg Imp: Resident Room &amp; Common Area Remodeling</u>	2001	46,868	4,685	10	4,685		46,868	49
50	<u>Bldg Imp: Carrier Units</u>	2001	3,080	205	15	205		2,053	50
51	<u>Bldg Imp: Garage &amp; Feasibility Study</u>	2002	4,588	459	10	459		3,901	51
52	<u>Bldg Imp: Overbed Lights; Closet Doors; Convector</u>	2002	21,597	1,440	15	1,440		12,240	52
53	<u>Bldg Imp: Tile work in Shower Rooms</u>	2002	2,267	113	20	113		963	53
54	<u>Bldg Imp: Sprinkler Work</u>	2003	9,840	394	8	394		2,953	54
55	<u>Bldg Imp: Halcyon Kitchen; Beauty shop; admin roof; entry door</u>	2004	13,838	1,384	10	1,384		8,996	55
56	<u>Bldg Imp: Halcyon Awning &amp; Convector</u>	2004	5,108	341	15	341		2,215	56
57	<u>Bldg Imp: Shower Repair</u>	2004	985	49	20	49		320	57
58	<u>Bldg Imp: Act. Office remodel; paint &amp; Tile; Motor for Boiler</u>	2005	676	68	10	68		373	58
59	<u>Bldg Imp: Air Conditioning 1st &amp; 2nd Stage Compressors</u>	2005	12,416	828	15	828		4,553	59
60	<u>Bldg Imp: Nurse Call System; Fire Wall Work</u>	2006	68,545	6,855	10	6,855		30,846	60
61	<u>Bldg Imp: Concrete Sidewalk</u>	2006	5,695	380	15	380		1,709	61
62	<u>Bldg Imp: Sewer Replacement &amp; Repair</u>	2006	7,193	288	25	288		1,295	62
63	<u>Bldg Imp: Admin Carpet</u>	2007	2,552	510	5	510		1,530	63
64	<u>Bldg Imp: Dining &amp; Kitchen Roof; Oasis Flooring</u>	2007	8,265	1,181	7	1,181		3,543	64
65	<u>Bldg Imp: Nook &amp; 80s Hall Remodel;LR Furnace;water heater; li</u>	2008	64,282	6,428	10	6,428		16,070	65
66	<u>Bldg Imp: Mop Sink</u>	2008	895	45	20	45		112	66
67	<u>Bldg Imp: Sprinkler System</u>	2008	3,288	132	25	132		330	67
68	<u>Bldg Imp: Halcyon Remodel - Cove Base, Chair Rail, Cubicle Cur</u>	2009	50,742	5,074	10	5,074		7,642	68
69	<u>Bldg Imp: Dishroom Remodel-plumbing, flooring, paint,</u>	2009	11,898	793	15	793		1,190	69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,722,128	\$ 86,363		\$ 86,363	\$	\$ 3,061,972	70

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

Facility Name &amp; ID Number Piatt County Nursing Home

# 0020255

Report Period Beginning:

12/01/09

Ending:

11/30/10

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,722,128	\$ 86,363		\$ 86,363	\$	\$ 3,061,972	1
2	Bldg Imp: Attic Access between PCNH & MP	2009	528	26	20	26		39	2
3	Grnds Imp	1976	954		10			954	3
4	Grnds Imp	1977	2,298		10			2,298	4
5	Grnds Imp	1978	1,729		10			1,729	5
6	Grnds Imp	1979	6,235		10			6,235	6
7	Grnds Imp	1980	3,031		10			3,031	7
8	Grnds Imp	1981	2,803		10			2,803	8
9	Grnds Imp	1982	1,196		10			1,196	9
10	Grnds Imp	1983	1,212		12			1,212	10
11	Grnds Imp	1984	7,796		10			7,796	11
12	Grnds Imp	1986	1,077		10			1,077	12
13	Grnds Imp	1987	6,713		3			6,713	13
14	Grnds Imp	1987	1,118		10			1,118	14
15	Grnds Imp	1989	11,701		10			11,701	15
16	Grnds Imp	1990	2,682		10			2,682	16
17	Grnds Imp	1992	51,409		10			51,409	17
18	Grnds Imp	1993	4,988		10			4,988	18
19	Grnds Imp: New Sign front/rear entrance; restripe lot	1996	9,884		10			9,884	19
20	Grnds Imp: Tree Removal & Evacuation	1998	8,691						20
21	Grnds Imp: ARD Awning; Truck Turnarounds; Sidewalk	1998	6,461		10			6,461	21
22	Grnds Imp: Tile Repair	1999	765		10			765	22
23	Grnds Imp: Conrete Patio	2000	2,107		10			2,107	23
24	Grnds Imp: Landscaping	2001	1,850		5			1,850	24
25	Grnds Imp: Surfacing, Striping * Patching of Parking Lot	2003	14,884	1,861	8	1,861		13,957	25
26	GASB 34 ADJ in 2004	2004	(16,641)					(16,641)	26
27	Grnds Imp: Drive Resurfacing	2007	1,300	87	5	87		304	27
28	Grnds Imp: Fence	2008	6,460	431	15	431		1,075	28
29	Grnds Imp: Smoking Hut	2008	2,637	132	20	132		329	29
30	Grnds Imp: Fence Removal	2009	4,382	292	15	292		438	30
31	Halcyon area: floor, walls, plumbing, sinks	2010	307,152	15,870	10	15,358	(512)	15,358	31
32	Paint & wallcovering	2010	10,751		5	1,075	1,075	1,075	32
33	Automatic doors	2010	11,346	571	10	571		571	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,201,627	\$ 105,633		\$ 106,196	\$ 563	\$ 3,206,486	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:

12/01/09

Ending:

11/30/10

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 12B, Carried Forward		\$ 4,201,627	\$ 105,633		\$ 106,196	\$ 563	\$ 3,206,486	1
2	Chiller water lines	2010	25,169	1,258	10	1,258		1,258	2
3	AC Furnace 180s hall	2010	12,897	645	10	645		645	3
4	Electrical upgrade outlets	2010	3,921	196	10	196		196	4
5	AC unit garage	2010	4,045	405	5	405		405	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	TOTAL (lines 1 thru 33)		\$ 4,247,659	\$ 108,137		\$ 108,700	\$ 563	\$ 3,208,990	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:

12/01/09

Ending:

11/30/10

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	\$ 532,619	\$ 44,624	\$ 54,405	\$ 9,781	10	\$ 341,632	71
72	Current Year Purchases	66,443	5,378	5,535	157		5,535	72
73	Fully Depreciated Assets	567,831					567,831	73
74								74
75	TOTALS	\$ 1,166,893	\$ 50,002	\$ 59,940	\$ 9,938		\$ 914,998	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)	\$ 5,449,552	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 158,139	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 168,640	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,501	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,123,988	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1975</u>	<u>Storage</u>		\$ <u>3,480</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>3,480</u>			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. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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 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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	4			4
3	Classroom Wages (a)	2,694			2,694
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation	1,200			1,200
7	Contractual Payments	90			90
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$ 3,988	\$	\$	\$ 3,988
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 3,988			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	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	\$	3,739	\$ 81,008	\$	3,739	\$ 81,008	1
2	Licensed Speech and Language Development Therapist		hrs		206	8,850		206	8,850	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		3,120	81,602		3,120	81,602	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			57,475			57,475	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab</u>					18,844			18,844	12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	7,065	\$ 247,779	\$	7,065	\$ 247,779	14

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

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **11/30/10**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 382,789	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	831,685		3
4	Supply Inventory (priced at )	54,063		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	314,068		8
9	Other(specify): <b>Funded Depr.</b>	281,656		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,864,261	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,000		13
14	Buildings, at Historical Cost	4,260,369		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,158,453		16
17	Accumulated Depreciation (book methods)	(4,108,187)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,345,635	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,209,896	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 394,184	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,465		30
31	Accrued Taxes Payable (excluding real estate taxes)	250,657		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>Provider assessment tax payable</b>	6,733		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 837,039	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 837,039	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,372,857	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,209,896	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,619,847</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,619,847</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(412,622)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Prior year correction</b>	<b>1,165,632</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>753,010</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,372,857</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,445,585	1
2	Discounts and Allowances for all Levels	(1,113,387)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,332,198	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	240,383	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 240,383	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	4,895	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,347	13
14	Non-Patient Meals	106,246	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	59,513	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,350	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 182,351	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	1,131,669	24
25	Interest and Other Investment Income***	2,251	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,133,920	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Maple Point Admin fee, rebates (see adjustments)</u>	54,819	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 54,819	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,943,671	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,418,026	31
32	Health Care	3,260,361	32
33	General Administration	1,378,661	33
	<b>B. Capital Expense</b>		
34	Ownership	161,619	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	76,319	35
36	Provider Participation Fee	54,900	36
	<b>D. Other Expenses (specify):</b>		
37	<u>PCS &amp; FIA expenses</u>	6,407	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,356,293	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(412,622)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (412,622)	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:

12/01/09

Ending:

11/30/10

**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	2,049	2,684	\$ 72,810	\$ 27.13	1
2	Assistant Director of Nursing	1,948	1,907	51,095	26.79	2
3	Registered Nurses	13,765	15,380	379,066	24.65	3
4	Licensed Practical Nurses	15,620	17,362	405,752	23.37	4
5	CNAs & Orderlies	91,098	96,496	1,344,973	13.94	5
6	CNA Trainees	332	332	2,694	8.11	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	346	346	5,621	16.25	9
10	Activity Assistants	9,643	10,659	122,913	11.53	10
11	Social Service Workers	2,621	3,195	42,873	13.42	11
12	Dietician					12
13	Food Service Supervisor	1,937	2,280	52,259	22.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,352	35,066	375,846	10.72	15
16	Dishwashers					16
17	Maintenance Workers	9,694	10,679	155,313	14.54	17
18	Housekeepers	10,351	11,201	131,947	11.78	18
19	Laundry	3,204	3,457	36,182	10.47	19
20	Administrator	1,848	2,168	73,627	33.96	20
21	Assistant Administrator					21
22	Other Administrative	8,672	9,771	168,247	17.22	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>Case Mgt &amp; Nsg S</u>	3,344	3,986	51,446	12.91	33
34	TOTAL (lines 1 - 33)	207,824	226,969	\$ 3,472,664 *	\$ 15.30	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	4,259	\$ 181,765	10-3	50
51	Licensed Practical Nurses	2,914	98,954	10-3	51
52	Certified Nurse Assistants/Aides	5,080	102,929	10-3	52
53	TOTAL (lines 50 - 52)	12,253	\$ 383,648		53

**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				
Kara Bradley	Executive Director	0	\$ 73,627	Workers' Compensation Insurance	\$ 60,000	IDPH License Fee	\$ 995				
				Unemployment Compensation Insurance	27,897	Advertising: Employee Recruitment	7,935				
				FICA Taxes	258,627	Health Care Worker Background Check					
				Employee Health Insurance	279,127	(Indicate # of checks performed <u>38</u> )	668				
				Employee Meals		Patient Background Checks	620				
				Illinois Municipal Retirement Fund (IMRF)*	277,199	Employers Association	513				
				Awards program	4,604	CLIA Laboratory Program	150				
				Other employee benefits	6,218	LSN	5,859				
				Medical - physicals	4,200						
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,627	TOTAL (agree to Schedule V, line 22, col.8)			\$ 917,872	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,740	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount	
			\$				\$	Out-of-State Travel		\$	
								In-State Travel			
								Seminar Expense		3,303	
								Entertainment Expense		( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 3,303	
C. Professional Services											
Vendor/Payee	Type		Amount								
Heather Sinclair	Graphic Design		\$ 165								
Kestrel Technologies	Website Design		1,720								
CJ Schlosser, CPAs	Medicare Cost Report		3,569								
May, Cocagne & King	Audit		17,000								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 22,454								

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13													
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
																	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	NA		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$												
2																									
3																									
4																									
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19																									
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$												

Facility Name & ID Number Piatt County Nursing Home# 0020255

Report Period Beginning:

12/01/09

Ending:

11/30/10**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. LSN \$5,859
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,717 Line 10
- (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. \$ 54,900  
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? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 15,410
- (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? \_\_\_\_\_  
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? NA  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: May, Cocagne & King
- (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? NA  
Attach invoices and a summary of services for all architect and appraisal fees