

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

<p>I. IDPH License ID Number: <u>0004234</u></p> <p>Facility Name: <u>SCOTT COUNTY NURSING CENTER</u></p> <p>Address: <u>650 N MAIN ST BX 110</u> <u>WINCHESTER</u> <u>62694</u> <small>Number City Zip Code</small></p> <p>County: <u>SCOTT</u></p> <p>Telephone Number: <u>(217) 742-3101</u> Fax # <u>(217) 742-5603</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>04/19/1971</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td> <input type="checkbox"/> Charitable Corp.</td> <td> <input type="checkbox"/> Individual</td> <td> <input type="checkbox"/> State</td> </tr> <tr> <td> <input type="checkbox"/> Trust</td> <td> <input type="checkbox"/> Partnership</td> <td> <input checked="" type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td> <input type="checkbox"/> Corporation</td> <td> <input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td> <input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td> <input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td> <input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td> <input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>KATHY PASCAL</u> Telephone Number: <u>(217) 742-3101</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/13</u> to <u>11/30/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1464 747 1653 950" rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>DEBBIE O'DELL</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>ADMINISTRATOR</u></td> <td></td> </tr> <tr> <td data-bbox="1464 950 1653 1234" rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>SUZANNE STECKEL</u> <u>PARTNER</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>ZUMBAHLEN, EYTH, SURRETT, FOOTE & FLYNN</u> <u>1395 LINCOLN AVE, JACKSONVILLE, IL 62650</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(217) 245-5121</u> Fax # <u>(217) 243-3356</u></td> <td></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>DEBBIE O'DELL</u>			(Title) <u>ADMINISTRATOR</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>SUZANNE STECKEL</u> <u>PARTNER</u>		(Firm Name & Address) <u>ZUMBAHLEN, EYTH, SURRETT, FOOTE & FLYNN</u> <u>1395 LINCOLN AVE, JACKSONVILLE, IL 62650</u>		(Telephone) <u>(217) 245-5121</u> Fax # <u>(217) 243-3356</u>	
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Facility Name & ID Number SCOTT COUNTY NURSING CENTER

0004234 Report Period Beginning: 12/1/13 Ending: 11/30/14

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	49	Skilled (SNF)	49	17,885	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	17,885	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			1,785	1,785	8
9	SNF/PED					9
10	ICF	10,723	4,108		14,831	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,723	4,108	1,785	16,616	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.90%

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 16,616

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 11/30 Fiscal Year: 11/30

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

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	163,747	9,322	4,320	177,389		177,389	177,389		1	
2	Food Purchase		107,997		107,997		107,997	107,997		2	
3	Housekeeping	109,797	9,063		118,860		118,860	118,860		3	
4	Laundry	19,398	3,056		22,454		22,454	22,454		4	
5	Heat and Other Utilities			65,168	65,168		65,168	65,168		5	
6	Maintenance	31,546	4,015	27,582	63,143		63,143	63,143		6	
7	Other (specify):*									7	
8	TOTAL General Services	324,488	133,453	97,070	555,011		555,011	555,011		8	
	B. Health Care and Programs										
9	Medical Director			9,450	9,450		9,450	9,450		9	
10	Nursing and Medical Records	1,128,338	185,363	354,806	1,668,507		1,668,507	1,668,507		10	
10a	Therapy									10a	
11	Activities	49,516	1,499	932	51,947		51,947	51,947		11	
12	Social Services	27,552			27,552		27,552	27,552		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,205,406	186,862	365,188	1,757,456		1,757,456	1,757,456		16	
	C. General Administration										
17	Administrative	59,480	20,440		79,920		79,920	79,920		17	
18	Directors Fees									18	
19	Professional Services			15,660	15,660		15,660	15,660		19	
20	Dues, Fees, Subscriptions & Promotions			10,452	10,452		10,452	10,452		20	
21	Clerical & General Office Expenses	35,664			35,664		35,664	42,611	6,947	21	
22	Employee Benefits & Payroll Taxes			123,791	123,791		123,791	338,822	215,031	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			9,577	9,577		9,577	9,577		24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			200	200		200	14,451	14,251	26	
27	Other (specify):*									27	
28	TOTAL General Administration	95,144	20,440	159,680	275,264		275,264	511,493	236,229	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,625,038	340,755	621,938	2,587,731		2,587,731	2,823,960	236,229	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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			63,609	63,609	63,609		63,609				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			63,609	63,609	63,609		63,609				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			122,722	122,722	122,722		122,722				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			122,722	122,722	122,722		122,722				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,625,038	340,755	808,269	2,774,062	2,774,062		236,229	3,010,291			45

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

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

0004234

Report Period Beginning: **12/1/13**

Ending: **11/30/14**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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				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)	\$		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

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

SCOTT COUNTY NURSING CENTER

ID# 0004234

Report Period Beginning: 12/1/13

Ending: 11/30/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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:

12/1/13

Ending:

11/30/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	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	6,947	0	0	0	0	0	0	0	0	0	6,947	21
22	Employee Benefits & Payroll Taxes	0	215,031	0	0	0	0	0	0	0	0	0	215,031	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	14,251	0	0	0	0	0	0	0	0	0	14,251	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	236,229	0	0	0	0	0	0	0	0	0	236,229	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	236,229	0	0	0	0	0	0	0	0	0	236,229	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SCOTT COUNTY NURSING CENTER# 0004234

Report Period Beginning:

12/1/13

Ending:

11/30/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	236,229	0	0	0	0	0	0	0	0	0	236,229	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21 CLERICAL	\$	SCOTT COUNTY		\$ 6,947	\$ 6,947	1
2	V	22 IMRF		SCOTT COUNTY		158,722	158,722	2
3	V	22 WORKMAN'S COMPENSATION		SCOTT COUNTY		40,837	40,837	3
4	V	22 UNEMPLOYMENT		SCOTT COUNTY		15,472	15,472	4
5	V	26 INSURANCE		SCOTT COUNTY		14,251	14,251	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		\$			\$ 236,229	\$ * 236,229	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: 12/1/13 Ending: 11/30/14

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:

12/1/13

Ending: 11/30/14

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization SCOTT COUNTY, ILLINOIS
 Street Address SCOTT COUNTY COURTHOUSE
 City / State / Zip Code WINCESTER, IL 62694
 Phone Number (217) 742-3368
 Fax Number (217) 742-5853

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	BOOKKEEPING	HOURS	2,080	2	\$ 34,734	\$ 28,649	416	\$ 6,947	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					\$ 34,734	\$ 28,649		\$ 6,947	25

Facility Name & ID Number SCOTT COUNTY NURSING CENTER

0004234

Report Period Beginning:

12/1/13

Ending:

11/30/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$	\$			\$					

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2013 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 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009 _____	8	FOR BHF USE ONLY			
	2010 _____	9				
	2011 _____	10				
	2012 _____	11				
	2013 _____	12				
			13	FROM R. E. TAX STATEMENT FOR 2013	\$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SCOTT COUNTY NURSING CENTER COUNTY SCOTT

FACILITY IDPH LICENSE NUMBER 0004234

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 2013 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 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 SCOTT COUNTY NURSING CENTER

0004234 Report Period Beginning:

12/1/13 Ending:

11/30/14

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? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>SITE</u>	<u>18,909</u>	<u>1970</u>	<u>\$ 1,567</u>	1
2					2
3	TOTALS	18,909		\$ 1,567	3

Facility Name & ID Number SCOTT COUNTY NURSING CENTER

0004234

Report Period Beginning:

12/1/13

Ending:

11/30/14

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$	40	\$	\$	\$ 174,649	4
5			1971	1971	1,500		20			1,500	5
6			1974	1974	20,633		37			20,633	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		20			1,565	14
15		SPRINKLER SYSTEM	1989		3,150		25			3,150	15
16		LIGHTS	1990		3,561		10			3,561	16
17		ROOF	1991		57,367		10			57,367	17
18		GARAGE	1991		9,291		20			9,291	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		101,932	22
23		PARKING LOT	1993		10,135		16			10,135	23
24		LAUNDRY	1995		22,174	739	30	739		14,411	24
25		GENERATOR FUEL TANK	1998		4,712	314	15	314		5,181	25
26		ELECTRICAL	1998		1,594		10			1,594	26
27		DINING ROOM	2000		274,460	9,149	30	9,149		132,660	27
28		PATIENT ROOM UPDATE - TILING & FURNITURE	2000		32,985		10			32,985	28
29		FULLY DEPRECIATED FIXED EQUIPMENT	1971		198,138		VAR			198,138	29
30		PATIENT ROOM UPDATE - TILING & FURNITURE	2001		24,779		10			24,779	30
31		SPRINKLER SYSTEM	2001		9,800	392	25	392		5,292	31
32		KITCHEN UPDATE - COOLER, VENT	2002		37,053	(1,855)	10	(1,855)		37,053	32
33		GENERATOR FUEL TANK	2005		13,787	1,379	10	1,379		13,100	33
34		FIRE ALARM UPDATE	2005		28,315	1,416	20	1,416		13,452	34
35		PATIENT ROOM UPDATE - HANDICAP ACCESSIBLE	2010		3,389	338	10	338		1,521	35
36		FRIENDSHIP GARDEN	2011		53,775	2,689	20	2,689		9,335	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:

12/1/13

Ending:

11/30/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	FIRE SPRINKLER SYSTEM	2013	\$ 29,778	\$ 1,191	25	\$ 1,191	\$	\$ 2,382	37
38	NURSES' STATION REMODEL	2014	3,151	158	10	158		158	38
39	3 HEATING & AIR UNITS	2014	2,145	67	16	67		67	39
40	ROOF	2014	486,753	24,338	10	24,338		24,338	40
41	OXYGEN SHED	2014	3,340	167	10	167		167	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)		\$ 1,720,427	\$ 45,222		\$ 45,222	\$	\$ 966,599	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 136,290	\$ 12,539	\$ 12,539	\$	10	\$ 89,621	71
72	Current Year Purchases	6,500	325	325		10	325	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 142,790	\$ 12,864	\$ 12,864	\$		\$ 89,946	75

D. Vehicle Costs. (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	\$ 5,523	\$ 5,523	\$	5	\$ 55,243	76
77										77
78										78
79										79
80	TOTALS			\$ 55,243	\$ 5,523	\$ 5,523	\$		\$ 55,243	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)	\$ 1,920,027	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 63,609	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,609	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)	\$ 1,111,788	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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/1/13 Ending: 11/30/14
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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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 prescrpts							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.

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

0004234

Report Period Beginning: **12/1/13**

Ending:

11/30/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **11/30/14** (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,085,275	\$ 1,085,275	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)	\$ 1,085,275	\$ 1,085,275	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	1,720,428	1,720,428	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	198,032	198,032	16
17	Accumulated Depreciation (book methods)	(1,111,788)	(1,111,788)	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)	\$ 808,239	\$ 808,239	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,893,514	\$ 1,893,514	25

		1 Operating	2 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	100,546	100,546	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 100,546	\$ 100,546	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	421,000	421,000	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)	\$ 421,000	\$ 421,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 521,546	\$ 521,546	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,371,968	\$ 1,371,968	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,893,514	\$ 1,893,514	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,272,885	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,272,885	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	99,083	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)	\$ 99,083	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)	\$ 1,371,968	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,862,976	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,862,976	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	2,780	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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		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)	\$ 2,780	23
D. Non-Operating Revenue			
24	Contributions	4,515	24
25	Interest and Other Investment Income***	2,874	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,389	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,873,145	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	555,011	31
32	Health Care	1,757,456	32
33	General Administration	275,264	33
B. Capital Expense			
34	Ownership	63,609	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	122,722	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,774,062	40
41	Income before Income Taxes (line 30 minus line 40)**	99,083	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 99,083	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,004,123	44
45	Private Pay - Net Inpatient Revenue	624,997	45
46	Medicare - Net Inpatient Revenue	814,542	46
47	Other-(specify) <u>SOCIAL SECURITY</u>	419,314	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,862,976	49

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

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

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

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

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

0004234

Report Period Beginning:

12/1/13

Ending:

11/30/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,633	2,077	\$ 54,306	\$ 26.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,742	3,123	75,725	24.25	3
4	Licensed Practical Nurses	19,264	21,763	456,578	20.98	4
5	CNAs & Orderlies	39,005	43,632	463,950	10.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,952	4,479	52,493	11.72	8
9	Activity Director	1,839	2,053	28,938	14.10	9
10	Activity Assistants	1,909	2,131	20,578	9.66	10
11	Social Service Workers	1,737	2,080	27,552	13.25	11
12	Dietician					12
13	Food Service Supervisor	1,777	2,064	26,265	12.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,676	14,121	137,482	9.74	15
16	Dishwashers					16
17	Maintenance Workers	1,922	2,080	31,546	15.17	17
18	Housekeepers	9,101	10,317	105,079	10.19	18
19	Laundry	1,506	1,699	19,398	11.42	19
20	Administrator	1,773	2,080	59,480	28.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,874	2,080	35,664	17.15	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	1,789	2,064	24,969	12.10	31
32	Other Health Care(specify)					32
33	Other(specify)	487	510	5,034	9.87	33
34	TOTAL (lines 1 - 33)	104,986	118,353	\$ 1,625,037 *	\$ 13.73	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	9,450	36
37	Medical Records Consultant	4	100	37
38	Nurse Consultant			38
39	Pharmacist Consultant	18	1,741	39
40	Physical Therapy Consultant	1,037	128,486	40
41	Occupational Therapy Consultant	1,016	121,252	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	322	57,051	43
44	Activity Consultant	12	932	44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	2,517	\$ 323,332	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

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

0004234

Report Period Beginning: **12/1/13**

Ending: **11/30/14**

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	
DEBBIE O'DELL	ADMINISTRATOR	0	\$ 59,480	Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	133,791	Health Care Worker Background Check (Indicate # of checks performed <u>5</u>)	183	
				Employee Health Insurance		Patient Background Checks	368	
				Employee Meals		IL HEALTH CARE ASSOCIATION	2,705	
				Illinois Municipal Retirement Fund (IMRF)*	158,722	IOPH PLAN REVIEW	6,000	
						JACKSONVILLE JOURNAL COURIER	529	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 59,480			DEBBIE O'DELL	613	
B. Administrative - Other						OTHER	605	
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
						TOTAL (agree to Sch. V, line 20, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 292,513	\$ 11,003		
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 & ASSOC.	AUDIT/ACC. SERVICES		\$ 7,590			\$	Out-of-State Travel	\$ 275
LTC SOLUTIONS	MDS/CARD PLANS		1,600					
REVVERE HEALTHCARE	MEDICARE AUDIT		4,730				In-State Travel	5,280
LLOYD VORTMAN COMPUTERS	TECHNICAL SUPPORT		1,740					
							Seminar Expense	4,047
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 15,660	TOTAL		\$	TOTAL	\$ 9,602

* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number SCOTT COUNTY NURSING CENTER

0004234

Report Period Beginning: 12/1/13

Ending: 11/30/14

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. ILLINOIS HEALTH CARE ASSOCIATION
- (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. \$ 25,996 Line _____
- (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. \$ 122,722
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? N/A
- (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? NO Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
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? 100
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: ZUMBAHLEN, EYTH, SURRETT, FOOTE & FLYNN, LTD
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.