FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: 0004234

Facility Name: SCOTT COUNTY NURSING CENTER

Address: 650 N MAIN ST BX 110 (Number) WINCHESTER (City) 62694 (Zip Code)

County: SCOTT

Telephone Number: (217) 742-3101 **Fax #** (217) 742-5603

HFS ID Number:

Date of Initial License for Current Owners: 04/19/1971

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DEBBIE O'DELL **Telephone Number:** (217) 742-3101
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2015 to 11/30/2016 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) DEBBIE O'DELL
(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) SUZANNE STECKEL, PARTNER
(Firm Name & Address) ZUMBAHLEN, EYTH, SURRATT, FOOTE & FLYNN, LTI, 1395 LINCOLN AVE, JACKSONVILLE IL 62650
(Telephone) (217) 245-5121 Fax # (217) 243-3356

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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,753	1,753	8
9	SNF/PED					9
10	ICF	7,653	4,126		11,779	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,653	4,126	1,753	13,532	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.66%

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 [X]

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

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 13,532

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [X] CASH* [ ]

Is your fiscal year identical to your tax year? YES [N/A] NO [ ]

Tax Year: N/A Fiscal Year: 11/30

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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	174,080	9,692	4,320	188,092		188,092		188,092			1
2	Food Purchase		95,270		95,270		95,270		95,270			2
3	Housekeeping	101,998	8,420		110,418		110,418		110,418			3
4	Laundry	20,729	1,684		22,413		22,413		22,413			4
5	Heat and Other Utilities			67,613	67,613		67,613		67,613			5
6	Maintenance	34,153	3,126	29,412	66,691		66,691		66,691			6
7	Other (specify):*											7
8	TOTAL General Services	330,960	118,192	101,345	550,497		550,497		550,497			8
	B. Health Care and Programs											
9	Medical Director			9,412	9,412		9,412		9,412			9
10	Nursing and Medical Records	1,135,836	205,493	37,447	1,378,776		1,378,776		1,378,776			10
10a	Therapy											10a
11	Activities	59,343	3,245	1,017	63,605		63,605		63,605			11
12	Social Services	11,241			11,241		11,241		11,241			12
13	CNA Training											13
14	Program Transportation		2,229	1,065	3,294		3,294		3,294			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,206,420	210,967	48,941	1,466,328		1,466,328		1,466,328			16
	C. General Administration											
17	Administrative	65,110			65,110		65,110		65,110			17
18	Directors Fees											18
19	Professional Services			13,400	13,400		13,400		13,400			19
20	Dues, Fees, Subscriptions & Promotions			5,809	5,809		5,809		5,809			20
21	Clerical & General Office Expenses	43,142	15,951		59,093		59,093	6,935	66,028			21
22	Employee Benefits & Payroll Taxes			125,582	125,582		125,582	186,431	312,013			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,526	4,526		4,526		4,526			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			200	200		200	14,292	14,492			26
27	Other (specify):*											27
28	TOTAL General Administration	108,252	15,951	149,517	273,720		273,720	207,658	481,378			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,645,632	345,110	299,803	2,290,545		2,290,545	207,658	2,498,203			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SCOTT COUNTY NURSING CENTER #0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			102,158	102,158		102,158		102,158			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,555	3,555		3,555	(2,830)	725			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			105,713	105,713		105,713	(2,830)	102,883			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			190,755	190,755		190,755		190,755			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,760	102,760		102,760		102,760			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			293,515	293,515		293,515		293,515			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,645,632	345,110	699,031	2,689,773		2,689,773	204,828	2,894,601			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: 12/01/2015 Ending: 11/30/2016

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(2,830)	32		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)**	$ (2,830)		$	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 Amount	2 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)	207,658		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 207,658		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 204,828		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 Yes	2 No	3 Amount	4 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: 12/01/2015

Ending: 11/30/2016

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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	6,935	0	0	0	0	0	0	0	0	0	6,935	21
22	Employee Benefits & Payroll Taxes	0	186,431	0	0	0	0	0	0	0	0	0	186,431	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	14,292	0	0	0	0	0	0	0	0	0	14,292	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	207,658	0	0	0	0	0	0	0	0	0	207,658	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	207,658	0	0	0	0	0	0	0	0	0	207,658	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 **Report Period Beginning:** 12/01/2015 **Ending:** 11/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,830)	0	0	0	0	0	0	0	0	0	0	(2,830)	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**	(2,830)	0	0	0	0	0	0	0	0	0	0	(2,830)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,830)	207,658	0	0	0	0	0	0	0	0	0	204,828	45

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Clerical	$	Scott County	100.00%	$ 6,935	$ 6,935	1
2	V	22	IMRF		Scott County	100.00%	137,034	137,034	2
3	V	22	Workmen's Compensation		Scott County	100.00%	40,787	40,787	3
4	V	22	Unemployment		Scott County	100.00%	8,610	8,610	4
5	V	26	General Insurance		Scott County	100.00%	14,292	14,292	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			$			$ 207,658	$ * 207,658	14

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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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

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

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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 1/30/2016

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 [X] NO [ ]

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

Name of Related Organization: Scott County, Illinois
Street Address: Scott County Courthouse
City / State / Zip Code: Winchester, IL 62694
Phone Number: (217) 742-3368
Fax Number: (217) 742-5853

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bookkeeping	Hours	2,080	2	$ 34,674	$ 29,038	416	$ 6,935	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					$ 34,674	$ 29,038		$ 6,935	25

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Natl. Bank of Winchester		X	New Roof on Building	$15,000.00	10/20/14	$ 421,000	$	10/20/16	0.0195	$ 3,555	1
2	First Natl. Bank of Winchester		X	New Roof on Building	$15,000.00	10/24/16	136,000	136,000	10/24/18	0.0195		2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$30,000.00		$ 557,000	$ 136,000			$ 3,555	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 557,000	$ 136,000			$ 3,555	15

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

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

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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 2015 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 2015.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 12/01/2015 Ending: 11/30/2016

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SITE	18,909	1970	$ 1,567	1
2					2
3	TOTALS	18,909		$ 1,567	3

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	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	GARAGE			1991	9,291		20			9,291	17
18	FOLDING DOOR			1991	1,751		10			1,751	18
19	ELECTRICAL			1992	3,018		10			3,018	19
20	COUNTER TOP			1992	1,920		6			1,920	20
21	BUILDING ADDITION			1993	142,244	4,741	30	4,741		111,415	21
22	PARKING LOT			1993	10,135		16			10,135	22
23	LAUNDRY			1995	22,174	739	30	739		15,889	23
24	GENERATOR FUEL TANK			1998	4,712		15			4,712	24
25	ELECTRICAL			1998	1,594		10			1,594	25
26	DINING ROOM			2000	274,460	9,149	30	9,149		150,958	26
27	PATIENT ROOM UPDATE - TILING & FURNITURE			2000	32,985		10			32,985	27
28	FULLY DEPRECIATED FIXED EQUIPMENT			1971	198,138		VAR			198,138	28
29	PATIENT ROOM UPDATE - TILING & FURNITURE			2001	24,779		10			24,779	29
30	SPRINKLER SYSTEM			2001	9,800	392	25	392		6,076	30
31	KITCHEN UPDATE - COOLER, VENT			2002	37,053		10			37,053	31
32	GENERATOR FUEL TANK			2005	13,787		10			13,787	32
33	FIRE ALARM UPDATE			2005	28,315	1,416	20	1,416		16,284	33
34	PATIENT ROOM UPDATE - HANDICAP ACCESSIBLE			2010	3,389	339	10	339		2,199	34
35	FRIENDSHIP GARDEN			2011	53,775	2,689	20	2,689		14,713	35
36	FIRE SPRINKLER SYSTEM			2013	29,778	1,191	25	1,191		4,764	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NURSES STATION REMODEL	2014	$ 3,151	$ 315	10	$ 315	$	$ 788	37
38	3 HEATING & AIR UNITS	2014	2,145	134	16	134		335	38
39	ROOFING PROJECT	2014	486,753	48,675	10	48,675		121,688	39
40	OXYGEN SHED	2014	3,340	334	10	334		835	40
41	FINISH ROOFING PROJECT	2015	125,966	12,597	10	12,597		18,895	41
42	WHIRLPOOL TUB	2015	11,639	1,164	10	1,164		1,746	42
43	SECURITY SYSTEM	2016	7,979	665	10	665		665	43
44	GENERATOR	2016	157,621	5,254	15	5,254		5,254	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)		$ 1,966,265	$ 89,794		$ 89,794	$	$ 1,076,240	70

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

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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	$ 121,201	$ 9,883	$ 9,883	$	10	$ 84,313	71
72	Current Year Purchases	49,617	2,481	2,481		10	2,481	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 170,818	$ 12,364	$ 12,364	$		$ 86,794	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 TRANSPORT	2009 CHEVROLET VAN	2009	$ 55,243	$	$	$	5	$ 55,243	76
77										77
78										78
79										79
80	TOTALS			$ 55,243	$	$	$		$ 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)	$ 2,193,893	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 102,158	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 102,158	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)	$ 1,218,277	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.

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 12/01/2015 Ending: 11/30/2016

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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

		1	2	3	4	5	6	7	8	
	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	Line 39, Col 3	hrs	$	930	$ 78,587	$	930	$ 78,587	1
2	Licensed Speech and Language Development Therapist	Line 39, Col 3	hrs		279	29,436		279	29,436	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 39, Col 3	hrs		892	82,732		892	82,732	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			$	2,101	$ 190,755	$	2,101	$ 190,755	14

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

STATE OF ILLINOIS

Facility Name & ID Number SCOTT COUNTY NURSING CENTER **#** 0004234 **Report Period Beginning:** 12/01/2015 **Ending:** 11/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/2016 **(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	$ 389,364	$ 389,364	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)**	$ 389,364	$ 389,364	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	1,966,265	1,966,265	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	226,061	226,061	16
17	Accumulated Depreciation (book methods)	(1,218,277)	(1,218,277)	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)**	$ 975,616	$ 975,616	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,364,980	$ 1,364,980	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	136,000	136,000	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)**	$ 136,000	$ 136,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 236,546	$ 236,546	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,128,434	$ 1,128,434	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,364,980	$ 1,364,980	48

***(See instructions.)**

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,353,673	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,353,673	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(225,239)	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)**	$ (225,239)	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)**	$ 1,128,434	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,458,927	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,458,927	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		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions	2,777	24
25	Interest and Other Investment Income***	2,830	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,607	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)**	$ 2,464,534	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	550,497	31
32	Health Care	1,466,328	32
33	General Administration	273,720	33
	B. Capital Expense		
34	Ownership	105,713	34
	C. Ancillary Expense		
35	Special Cost Centers	190,755	35
36	Provider Participation Fee	102,760	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,689,773	40
41	**Income before Income Taxes (line 30 minus line 40)****	(225,239)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (225,239)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 740,000	44
45	Private Pay - Net Inpatient Revenue	624,451	45
46	Medicare - Net Inpatient Revenue	849,205	46
47	Other-(specify) Social Security	242,386	47
48	Other-(specify) Hospice	2,885	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,458,927	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: 12/01/2015 Ending: 11/30/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,774	2,160	$ 58,950	$ 27.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,394	6,461	166,069	25.70	3
4	Licensed Practical Nurses	16,737	19,791	425,639	21.51	4
5	CNAs & Orderlies	34,627	40,008	431,268	10.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,924	2,304	26,363	11.44	8
9	Activity Director	1,823	2,128	29,483	13.85	9
10	Activity Assistants	2,646	2,952	29,600	10.03	10
11	Social Service Workers	739	778	11,565	14.87	11
12	Dietician					12
13	Food Service Supervisor	1,822	2,160	26,638	12.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,910	14,622	147,455	10.08	15
16	Dishwashers					16
17	Maintenance Workers	1,920	2,160	34,153	15.81	17
18	Housekeepers	7,608	8,655	91,137	10.53	18
19	Laundry	1,563	1,758	20,920	11.90	19
20	Administrator	1,825	2,145	65,110	30.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,145	2,389	43,142	18.06	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	1,867	2,175	27,469	12.63	31
32	Other Health Care(specify)					32
33	Other(specify) Bed Maker	1,097	1,173	10,671	9.10	33
34	TOTAL (lines 1 - 33)	98,421	113,819	$ 1,645,632 *	$ 14.46	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,320	Line 1 Col 3	35
36	Medical Director	12	9,412	Line 9 Col 3	36
37	Medical Records Consultant	4	100	Line 10 Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	2,716	Line 10 Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	1,017	Line 11 Col 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	160	$ 17,565		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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: 12/01/2015 Ending: 11/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debbie O'Dell	Administrator	N/A	$ 65,110
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 65,110

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Revere Healthcare	Medicare Audit	$ 4,958
Zumbahlen & Associates	Audit/Accounting Service	7,421
Lloyd Vortman Computer Svc.	Computer Support	1,021
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 13,400

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,787
Unemployment Compensation Insurance	8,610
FICA Taxes	125,582
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	137,034
TOTAL (agree to Schedule V, line 22, col.8)	$ 312,013

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	579
Health Care Worker Background Check	
(Indicate # of checks performed 5)	175
Patient Background Checks 26	416
Illinois Health Care Association	3,234
Magazine/Newspaper Subscriptions	856
MES/HSPI of Illinois	175
CLIA Laboratory Program	150
Professional Licenses	224
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,809

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
SEE ATTACHED EXPLANATION	705
In-State Travel	
SEE ATTACHED EXPLANATION	944
Seminar Expense	
SEE ATTACHED EXPLANATION	2,877
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,526

* Attach copy of IMRF notifications

**See instructions.

Final Notice of Illinois Municipal Retirement Fund
Contribution Rate for Calendar Year 2015

Date: November 2014

Employer name: [redacted] [redacted]

The contribution rates on earnings paid by your participating governmental unit to IMRF members are shown below. The Illinois Pension Code provides that the employer is responsible for remitting both employee and member contributions to IMRF along with the related deposit report according to prescribed due dates.

IMRF contributions must be paid on the earnings of all employees working in participating positions. Your employer contribution rate on member earnings is based upon actuarial costs for retirement, supplemental retirement, death, and disability benefits. The actuarial formula is specified in the Illinois Pension Code. Member contributions are specified in the Illinois Pension Code and help to meet the cost of future retirement benefits.

Participating governmental units with taxing powers are authorized by the Illinois Pension Code to levy a special IMRF tax for payment of employer IMRF contributions. However, this levy may be used only for employer payments. It may not be used for payment of IMRF member contributions. These must be paid out of the same fund from which the employee IMRF earnings are paid. Interest charges are assessed on any late payments. Refer to Section 4 of the IMRF Manual for Authorized Agents for interest charge procedures. If you have any questions, please contact the IMRF Employer Account Analyst at 1-800-ASK-IMRF.

Lou's W. Kealbe, Executive Director

	IMRF Contributions Regular	SLEP	ECO
Member Contributions (tax deferred)			
Employer Contributions			
* **Retirement Rate**			
Normal Cost	[redacted]		
Funding Adjustment <over> under			
Net Retirement Rate			
* **Other Program Benefits**			
Death			
Disability			
Supplemental Benefit Payment			
Early Retirement Incentive			
SLEP Enhancement			
* **TOTAL EMPLOYER RATE**			

SCOTT COUNTY
DONNA J. MONTGOMERY, TREASURER
311 E MARKET ST Ste 4
SCOTT COUNTY COURT HOUSE STE 4
WINCHESTER IL 62694-1227

Scott County Nursing Center
Explanation for XIX Part G.
2016 LTC Cost Report

Out-of-State Travel:

Names of individuals attending seminar:	[redacted]
	[redacted] R.N., Administrator
	[redacted], MDS Coordinator
Dates attended:	7/11/16 and 7/12/16
Location:	Cedar Rapids, Iowa
Title of seminar:	Medicare Informational Seminar
Sponsor of seminar:	Health Care Information Systems and Medi-Bill Systems, 450 Regency Parkway, Suite 100, Omaha, NE 68114
Amount paid for seminar:	$0
Amount of mileage paid:	$279
Amount of meals/hotel paid:	$426
Total Out-of-State Travel	**$705**

In-State Travel:

Miscellaneous employee mileage to pick up office supplies, activities supplies, housekeeping supplies, and perform patient screenings	$342
Hotel/meals expense for conference on 4/20/16 and 4/21/16 in Springfield, IL	$302
Mileage paid for employee to attend a wound center meeting in Quincy, IL	$72
Mileage paid for employee to attend an Omnicare meeting in Decatur, IL	$104
Mileage paid for employee to attend a conference on 6/29/16 in Springfield, IL	$63
Mileage paid to employee to attend a conference on 11/2/16 and 11/3/16 in Springfield, IL	$61
Total In-State Travel	**$944**

Seminar Expense:

Illinois Health Care Assoc., 19th Annual Resources for Success, Springfield, IL, 4/20/16 and 4/21/16 (6 attendees)	$1,200
Meals reimbursed to employees during conference 4/20/16 and 4/21/16	$47
Illinois Health Care Assoc., New Rehospitalization & Quality Measures, Springfield, IL, 6/29/16 (4 attendees)	$380
Greene County Health Dept., Food Service Sanitation Manager 8-hr. Certification, 11/5/16 (2 attendees)	$200
Outcome Services of Illinois, 36-Hour Activity Director's Correspondence Course, online, September 2016 (1 attendee)	$525
Blessing Hospital Educational Services, 2016 Fall Wound Conference, Quincy, IL, 10/11/16 (2 attendees)	$150
Illinois Nursing Home Administrator's Assoc., 2016 Annual Convention and Trade Show, Springfield, IL, 11/2/16 and 11/3/16 (3 attendees)	$375
Total Seminar Expense	**$2,877**

Facility Name & ID Number SCOTT COUNTY NURSING CENTER # 0004234 Report Period Beginning: 12/01/2015 Ending: 11/30/2016

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 $3,234**

(3) Did the nursing home make political contributions or payments to a politica
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? **10.63 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **11,710** 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 fo
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 Departmen
during this cost report period. $ **102,760**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **N/A** 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. $ **N/A** Has any meal income been offset against
related costs? **N/A** 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 fo
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, Surratt, Foote & Flynn, Ltd.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **N/A**

(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