FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 0020255

Facility Name: Piatt County Nursing Home

Address: 1111 N State St B410 (Number) Monticello (City) 61856 (Zip Code)

County: Piatt

Telephone Number: (217) 762-2506 **Fax #** (217) 762-2507

HFS ID Number:

Date of Initial License for Current Owners: 12/1/1973

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: Scott Porter **Telephone Number:** (217) 762-2506
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 12/01/2019 to 11/30/2020 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)
	(Title)
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) Fax #

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 Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	100	Skilled (SNF)	100	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,034	14,057	1,521	28,612	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,034	14,057	1,521	28,612	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.17%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 12/1/1973

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 100 and days of care provided 1,083

Medicare Intermediary National Goverment Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/2020 Fiscal Year: 11/30/2020

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

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	514,028	47,109	8,153	569,290		569,290		569,290			1
2	Food Purchase		309,111		309,111		309,111	(43,088)	266,023			2
3	Housekeeping	230,115	39,472	-	269,587		269,587		269,587			3
4	Laundry	30,909	14,113	-	45,022		45,022		45,022			4
5	Heat and Other Utilities			95,567	95,567		95,567		95,567			5
6	Maintenance	167,716	54,046	30,542	252,304		252,304		252,304			6
7	Other (specify):*	-	-	-								7
8	TOTAL General Services	942,768	463,851	134,262	1,540,881		1,540,881	(43,088)	1,497,793			8
	B. Health Care and Programs											
9	Medical Director	-	-	16,000	16,000		16,000		16,000			9
10	Nursing and Medical Records	3,010,157	224,187	70,253	3,304,597		3,304,597		3,304,597			10
10a	Therapy	-	-	-								10a
11	Activities	182,015	14,785	857	197,657		197,657		197,657			11
12	Social Services	133,092	16,093	408	149,593		149,593		149,593			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	TOTAL Health Care and Programs	3,325,264	255,065	87,518	3,667,847		3,667,847		3,667,847			16
	C. General Administration											
17	Administrative	178,358	12,436	-	190,794		190,794		190,794			17
18	Directors Fees			-								18
19	Professional Services			94,658	94,658		94,658		94,658			19
20	Dues, Fees, Subscriptions & Promotions			45,371	45,371		45,371	(900)	44,471			20
21	Clerical & General Office Expenses	220,809	16,840	27,382	265,031		265,031	(12,955)	252,076			21
22	Employee Benefits & Payroll Taxes			1,199,941	1,199,941		1,199,941		1,199,941			22
23	Inservice Training & Education			4,512	4,512		4,512		4,512			23
24	Travel and Seminar			1,029	1,029		1,029		1,029			24
25	Other Admin. Staff Transportation		-	-								25
26	Insurance-Prop.Liab.Malpractice			85,030	85,030		85,030		85,030			26
27	Other (specify):*			-								27
28	TOTAL General Administration	399,167	29,276	1,457,923	1,886,366		1,886,366	(13,855)	1,872,511			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,667,199	748,192	1,679,703	7,095,094		7,095,094	(56,943)	7,038,151			29

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

Facility Name & ID Number Piatt County Nursing Home #0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			170,290	170,290		170,290	3,191	173,481			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			203	203		203	(203)				32
33	Real Estate Taxes			-								33
34	Rent-Facility & Grounds			-								34
35	Rent-Equipment & Vehicles			13,163	13,163		13,163		13,163			35
36	Other (specify):*			-								36
37	**TOTAL Ownership**			183,656	183,656		183,656	2,988	186,644			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	72,847	276,805	349,652		349,652		349,652			39
40	Barber and Beauty Shops	-	2,295	-	2,295		2,295		2,295			40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			222,755	222,755		222,755		222,755			42
43	Other (specify):* Non-Allowable Cos	-	-	215,926	215,926		215,926	(215,926)				43
44	**TOTAL Special Cost Centers**		75,142	715,486	790,628		790,628	(215,926)	574,702			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,667,199	823,334	2,578,845	8,069,378		8,069,378	(269,881)	7,799,497			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 Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	(43,088)	02		4
5	Telephone, TV & Radio in Resident Rooms	(10,005)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,191	30		9
10	Interest and Other Investment Income	(203)	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	(193,428)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(26,348)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (269,881)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (269,881)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Piatt County Nursing Home

ID# 0020255

Report Period Beginning: 12/01/2019

Ending: 11/30/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying Dues	$ (487)	20	1
2	Medicare Part A Labs	(1,460)	43	2
3	Medicare Part A Xrays	(3,341)	43	3
4	Medicare Part A Other	(2,356)	43	4
5	Resdient Replacement Items	(3,277)	43	5
6	Disallow Civic Organizations	(413)	20	6
7	Marketing Expenses	(2,059)	43	7
8	Miscellaneous Income	(12,955)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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**	(26,348)		49

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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
Piatt County	100%			Maple Point	Monticello	Supportive Living

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	22	IMRF	$ 354,786	Piatt County	100%	$ 354,786	$	1
2	V	22	Social Security	343,377	Piatt County	100%	343,377		2
3	V	22	Unemployment	52,823	Piatt County	100%	52,823		3
4	V	22	Insurance	95,290	Piatt County	100%	95,290		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 846,276			$ 846,276	$ * 0	14

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

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	Ray Spencer	Board Chairman	Administrative						$	N/A	1
2	Randy Shumard	Board Vice Chairman	Administrative							N/A	2
3	Dale Lattz	Member	Administrative							N/A	3
4	Renee Fruendt	Member	Administrative							N/A	4
5	Shannon Carroll	Member	Administrative							N/A	5
6	Robert Murrell	Member	Administrative							N/A	6
7											7
8											8
9											9
10	No members of the operating board provide services to the county.										10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 1/30/2020

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 [X]

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

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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		N/A				$	$		$	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
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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							$	$			$	1
2	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	Various			Finance Charges							203	8
9	TOTAL Facility Related						$	$			$ 203	9
	B. Non-Facility Related*											
10												10
11												11
12									Disallow Interest Income		(203)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (203)	14
15	TOTALS (line 9+line14)						$	$			$	15

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

* 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 Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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.)	2019	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2020 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.)**	**Alloc. Fr. Mgmt. Co.**	$	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:			
	2015	N/A	8
	2016		9
	2017		10
	2018		11
	2019		12

Facility Does Not Pay Real Estate Taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Piatt County Nursing Home COUNTY Piatt

FACILITY IDPH LICENSE NUMBER 0020255

CONTACT PERSON REGARDING THIS REPORT Scott Porter

TELEPHONE (217) 762-2506 FAX #: (217) 762-2507

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	County Facility - exempt from real estate taxes.		$	$
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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,120 B. General Construction Type: Exterior Brick Frame Comb. Number of Stories 1

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. [X] (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).

Maple Point Supportive Living Facility - 30 apartments licensed for 46 beds.

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	Facility	182,592	1972	$ 35,000	1
2					2
3	TOTALS	182,592		$ 35,000	3

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	60			1973	$ 800,000	$	30	$	$	$ 800,000	4
5	36			1974	525,102		30			525,102	5
6	4			1989	886,044		30	3,655	3,655	886,044	6
7				1993	244,299	8,143	30	8,143		223,945	7
8											8
	Improvement Type**										
9	Various			1976	8,084		20			8,084	9
10	Various			1977	10,534		20			10,534	10
11	Various			1978	2,270		20			2,270	11
12	Various			1979	10,489		20			10,489	12
13	Various			1980	173,863		20			173,863	13
14	Various			1981	9,079		20			9,079	14
15	Various			1982	8,156		20			8,156	15
16	Various			1983	58,083		20			58,083	16
17	Various			1984	18,377		20			18,377	17
18	Various			1985	19,277		20			19,277	18
19	Various			1986	12,964		20			12,964	19
20	Various			1987	21,924		20			21,924	20
21	Various			1988	50,282		20			50,282	21
22	Various			1989	102,364		20			102,364	22
23	Various			1990	16,518		20			16,518	23
24	Various			1991	48,204		20			48,204	24
25	Various			1992	56,941		20			56,941	25
26	Various			1993	26,024		20			26,024	26
27	Various			1994	5,888		20			5,888	27
28	Various			1995	8,381		20			8,381	28
29	Various			1996	17,466		20			17,466	29
30	Various			1997	227,748		20			227,748	30
31	Various			1998	24,575		20			24,575	31
32	Various			1999	97,560		20			97,560	32
33	Various			2000	32,090		20			32,090	33
34	Various			2001	50,226		20	2,511	2,511	50,226	34
35	Various			2002	20,727		20	1,036	1,036	19,691	35
36	Various			2003	24,724		20	1,236	1,236	22,252	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	Various	2004	$ 1,846	$	20	$ 92	$ 92	$ 1,569	37
38	Various	2005	12,416		20	621	621	9,933	38
39	Various	2006	79,297		20	3,965	3,965	59,473	39
40	Various	2007	10,817		20	541	541	7,572	40
41	Various	2008	72,060		20	3,603	3,603	46,839	41
42	Various	2009	62,363		20	3,118	3,118	37,418	42
43	Various	2010	351,674		20	17,584	17,584	193,421	43
44	Various	2011	73,978		20	3,158	3,158	47,613	44
45	Various	2012	28,964		20	1,448	1,448	25,059	45
46	Various	2013	134,728		20	6,736	6,736	53,893	46
47	Various	2014	39,153		20	1,958	1,958	16,057	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)		$ 4,485,559	$ 8,143		$ 59,406	$ 51,262	$ 4,093,246	70

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

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	
1	Totals from Page 12A, Carried Forward		$ 4,485,559	$ 8,143		$ 59,406	$ 51,262	$ 4,093,246	1
2	Rms 159-174 And 170'S Hallway-Walls, Lighting, Floorings, Fixtur	2015	139,604		20	6,980	6,980	41,881	2
3	Plumbing In Hall 170 Shower Rm & Ard Unit Shower Rm	2015	20,165		20	1,008	1,008	6,050	3
4	Awning For Patio	2015	5,676		20	284	284	1,703	4
5	Aviary	2015	6,694		20	335	335	2,008	5
6	Wall Kiosks In Halls 170, 180, 150, 140 & Ard Unit	2015	6,752		20	338	338	2,026	6
7	Shower Room: New Shower, Drain Wall Boards	2016	10,536		20	527	527	2,634	7
8	Flooring: Hallway 50 & 60	2016	13,814		20	691	691	3,454	8
9	Boiler Room Materials	2016	5,494		20	275	275	1,374	9
10	Curtain Tracks	2016	5,665		20	283	283	1,416	10
11	Hall Convectors	2016	4,480		20	224	224	1,120	11
12	Wanderguard	2016	2,689		20	269	269	1,345	12
13	Electrical Work	2016	2,965		20	148	148	741	13
14	Fire Hydrant Installation	2016	12,992		20	650	650	3,248	14
15	Remodel - Mirrors, Convectors	2016	39,269		20	1,963	1,963	9,817	15
16	Remodel - Room Convectors	2016	11,921		20	596	596	2,980	16
17	New Water Heater	2016	14,417		20	721	721	2,883	17
18	Vinyl Wood Planks For Nursing Station Hallway & Res Rms, Floor	2016	46,578		20	2,329	2,329	9,316	18
19	Double Door Fire Replacement	2017	8,996		20	450	450	1,799	19
20	Fan Coil Air Conditioners	2017	2,676		20	134	134	535	20
21	140S Hallway Cornerguards	2017	3,485		20	174	174	697	21
22	Skylights & Verandas For Resident Rooms	2017	3,473		20	174	174	695	22
23	Wiring For Desk A, 170S Hall And Activities Room	2017	5,651		20	283	283	1,130	23
24	Repaired Kitchen Drain/Ice Maker Line	2018	3,748		20	187	187	562	24
25	Repaired Roof	2018	14,616		20	731	731	2,192	25
26	Repaired Fan Coil Replacement	2018	5,252		20	263	263	788	26
27	Replaced Boiler	2018	20,468		20	1,023	1,023	3,070	27
28									28
29	Replace Mansard Roof	2019	14,966		20	748	748	1,122	29
30	Wiring/Network Extensions	2019	5,233		10	523	523	785	30
31	Exhaust Fan - Kitchen	2019	19,806		10	1,981	1,981	2,971	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,943,641	$ 8,143		$ 83,696	$ 75,553	$ 4,203,588	34

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

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	
1	Totals from Page 12B, Carried Forward		$ 4,943,641	$ 8,143		$ 83,696	$ 75,553	$ 4,203,588	1
2									2
3	Drip Lines in Irrigation System - Courtyard	2020	3,250		15	108	108	108	3
4	Nurse Call System - R5000 - Entire Bldg	2020	12,447		10	622	622	622	4
5	Trane Chiller Sensor - Mechanical Room	2020	4,447		5	445	445	445	5
6	Dining Room Remodel - Repr & Paint Walls, Flooring, Lighting	2020	32,323		10	1,616	1,616	1,616	6
7	Replace Expansion Joints - Entire Bldg	2020	9,966		10	498	498	498	7
8	Snoozelen Room - Wall mount equip & technology - Halcyon Unit	2020	26,537		10	1,327	1,327	1,327	8
9									9
10									10
11	To Adjust to Financial Statements			79,312			(79,312)		11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,032,611	$ 87,455		$ 88,313	$ 858	$ 4,208,205	34

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

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	$ 1,034,486	$ 79,545	$ 79,545	$	10 years	$ 962,206	71
72	Current Year Purchases	47,537	3,290	3,290		5-10 years	3,290	72
73	Fully Depreciated Assets	567,831					567,831	73
74								74
75	TOTALS	$ 1,649,854	$ 82,835	$ 82,835	$		$ 1,533,327	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	Resident Care	Chrysler Van	2013	$ 43,226	$ -	$ -	$	5	$ 43,226	76
77	Resident Care	Van	2015	23,332	-	2,333	2,333	10	13,999	77
78					-	-				78
79					-	-				79
80	TOTALS			$ 66,558	$	$ 2,333	$ 2,333		$ 57,225	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)	$ 6,784,023	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 170,290	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 173,481	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,191	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,798,757	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ N/A	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 Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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.	/2021	$
13.	/2022	$
14.	/2023	$

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: ☐ YES ☒ N/A NO Terms: N/A *

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: $ 13,163 Description: Postage Machine $2,608, Copier $10,381, Maintenance $174
(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			$ N/A	$	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 Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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

It is the policy of this facility to only hire certified nurses aides.

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.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	1,483	$ 106,749	$	1,483	$ 106,749	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		651	46,861		651	46,861	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,711	123,195		1,711	123,195	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				58,742		58,742	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					14,105		14,105	12
13	Other (specify):									13
14	TOTAL			$	3,845	$ 276,805	$ 72,847	3,845	$ 349,652	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 Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2020 (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	$ 1,518,723	$ 1,518,723	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 172,412)	596,859	596,859	3
4	Supply Inventory (priced at)	69,945	69,945	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	-	-	6
7	Other Prepaid Expenses	4,650	4,650	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): CARES Funding	97,337	97,337	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,287,514	$ 2,287,514	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	35,000	35,000	13
14	Buildings, at Historical Cost	2,431,998	2,455,445	14
15	Leasehold Improvements, at Historical Cost	1,781,120	2,577,166	15
16	Equipment, at Historical Cost	1,128,776	1,716,412	16
17	Accumulated Depreciation (book methods)	(4,038,014)	(5,798,757)	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 (spe	-	-	22
23	Other(specify):	-	-	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,338,880	$ 985,266	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,626,394	$ 3,272,780	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 210,470	$ 210,470	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	-	-	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	160,164	160,164	30
31	Accrued Taxes Payable (excluding real estate taxes)	41,612	41,612	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	167,281	167,281	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	176,762	176,762	36
37		-	-	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 756,289	$ 756,289	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	-	-	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	-	-	41
42	Deferred Compensation	-	-	42
	Other Long-Term Liabilities(specify):			
43	Due to PCNH Foundation	1,543,283	1,543,283	43
44		-	-	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,543,283	$ 1,543,283	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,299,572	$ 2,299,572	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,326,822	$ 973,208	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,626,394	$ 3,272,780	48

*(See instructions.)

Facility Name: **Piatt County Nursing Home**
IDPH License ID Number: **0020255**
Fiscal Year End: **11/30/2020**

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
2130	Due to Piatt County - IL Funds	5,625	5,625
2240	Employee Deduct-Court Ordered	108	108
2245	Employe Deduct - Credit Union	400	400
2250	Employee Deductions - Misc.	184	184
2260	Section 125	15,333	15,333
2265	IMRF Insurance	46	46
2275	AFLAC Int Care	2,029	2,029
2290	IMRF Retirement	8,287	8,287
2310	Accrued Monthly Assessment	39,528	39,528
2335	Resident Trust	8,368	8,368
2360	Deferred Revenue	96,854	96,854
	Total - Line 36	**176,762**	**176,762**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,142,763	1
2	Restatements (describe):		2
3	Equity Adjustment	(1,649,394)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 493,369	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	833,453	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)**	$ 833,453	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)**	$ 1,326,822	24 *

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

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	$ 6,258,882	1
2	Discounts and Allowances for all Levels	162,889	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,421,771	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	128,740	6
7	Oxygen	-	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 128,740	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	617,351	10
11	CNA Training Reimbursements	-	11
12	Gift and Coffee Shop	-	12
13	Barber and Beauty Care	2,608	13
14	Non-Patient Meals	43,088	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)**	$ 663,047	23
	D. Non-Operating Revenue		
24	Contributions	22,272	24
25	Interest and Other Investment Income***	1,788	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,060	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,665,213	28
28a		-	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,665,213	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,902,831	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,540,881	31
32	Health Care	3,667,847	32
33	General Administration	1,886,366	33
	B. Capital Expense		
34	Ownership	183,656	34
	C. Ancillary Expense		
35	Special Cost Centers	567,873	35
36	Provider Participation Fee	222,755	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,069,378	40
41	**Income before Income Taxes (line 30 minus line 40)****	833,453	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 833,453	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,367,538	44
45	Private Pay - Net Inpatient Revenue	3,228,282	45
46	Medicare - Net Inpatient Revenue	525,087	46
47	Other-(specify) MRR	300,864	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,421,771	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.**

^Entity is a cash basis taxpayer.

Facility Name: **Piatt County Nursing Home**
IDPH License ID Number: **0020255**
Fiscal Year End: **11/30/2020**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

	Description	Amount
4701	Bad Debt Recovery	8,885
4703	Faith In Action	33,681
4705	IGT Reimbursement	167,023
4706	Miscellaneous Income	106,741
4709	PCSS	36,660
4710	Property Tax Levy	465,947
4721	IMRF Revenue	354,786
4722	Social Security Revenue	343,377
4723	Unemployment Revenue	52,823
4724	Worker's Comp Revenue	95,290
	Total - Line 28	**1,665,213**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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	1,940	2,129	$ 79,261	$ 37.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,709	14,121	487,449	34.52	3
4	Licensed Practical Nurses	21,327	22,121	624,490	28.23	4
5	CNAs & Orderlies	92,783	94,840	1,733,618	18.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,958	2,080	46,993	22.59	9
10	Activity Assistants	8,782	8,782	135,022	15.37	10
11	Social Service Workers	2,111	2,261	54,814	24.24	11
12	Dietician					12
13	Food Service Supervisor	1,912	2,086	52,143	25.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,945	33,457	461,885	13.81	15
16	Dishwashers					16
17	Maintenance Workers	8,937	9,481	167,716	17.69	17
18	Housekeepers	17,085	17,450	230,115	13.19	18
19	Laundry	2,003	2,456	30,909	12.59	19
20	Administrator	1,800	2,080	90,791	43.65	20
21	Assistant Administrator	1,943	2,080	87,567	42.10	21
22	Other Administrative	2,563	2,773	70,025	25.25	22
23	Office Manager					23
24	Clerical	4,300	4,460	92,003	20.63	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	2,017	2,017	39,575	19.62	31
32	Other Health C: See SCH 20A	3,571	4,367	104,545	23.94	32
33	Other(specify) See SCH 20A	3,659	3,832	78,278	20.43	33
34	TOTAL (lines 1 - 33)	224,345	232,873	$ 4,667,199 *	$ 20.04	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	Monthly	$ 8,153	1(3)	35
36	Medical Director	Monthly	16,000	9(3)	36
37	Medical Records Consultant	Monthly	1,805	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,958	10(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	Monthly	857	11(3)	44
45	Social Service Consultant	Monthly	408	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 30,181		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name: **Piatt County Nursing Home**
IDPH License ID Number: **0020255**
Fiscal Year End: **11/30/2020**

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Admissions	2,215	2,633	58,782	$ 22.33
Dental	1,356	1,734	45,763	$ 26.39
Total - Line 32 Other Health Care (specify):	**3,571**	**4,367**	**104,545**	

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
PCSS Director	1,808	1,861	46,543	$ 25.01
FIA Director	1,851	1,971	31,735	$ 16.10
Total - Line 33 Other (specify):	**3,659**	**3,832**	**78,278**	

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott Porter	Administrator	0.00%	$ 90,791
Stephanie Berkey	Assist Administrator	0.00%	87,567
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 178,358

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Kronos	Payroll Software	$ 22,661
May, Cocagne & King PC	Accounting	21,750
Kelly's Accounting Service	Accounting	1,508
RSM US LLP	Accounting	9,338
Marcum LLP	Accounting	500
Kestrel Techonology	Website Hosting	1,440
Viscon	Computer Consulting	37,461
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 94,658

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,290
Unemployment Compensation Insurance	52,823
FICA Taxes	344,996
Employee Health Insurance	238,561
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	354,786
Other Employee Benefits	113,485
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,199,941

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	136
Health Care Worker Background Check	
(Indicate # of checks performed 283)	2,825
Patient Background Checks 17	510
Dues and Subscriptions	12,999
LeadingAge	8,110
Less: Lobbying Dues	(487)
Ability Network	14,554
Miscellaneous Licenses & Fees	6,237
Less: Rotary dues	(413)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,471

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,029
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,029

**See instructions.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/2019 Ending: 11/30/2020

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. **Leading Age $8,110**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **N/A**

(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? **5-10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **64,397** 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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **222,755**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **-** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **43,088**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 1**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **May. Cocagne, & King**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.