		FOR BHF USE					

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0000497

Facility Name: RANDOPH COUNTY CARE CENTER

Address: 312 WEST BELMONT (Number) SPARTA (City) 62286 (Zip Code)

County: RANDOLPH

Telephone Number: 618-443-4351 **Fax #** 618-443-2700

HFS ID Number:

Date of Initial License for Current Owners: 1953

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: ROGER W. BAGLEY **Telephone Number:** 618-549-8331
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 12/01/2009 to 11/30/2010 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) ROGER W. BAGLEY
(Title) CONTROLLER

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 RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

III. STATISTICAL DATA

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

	1 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	47	Skilled (SNF)	47	17,155	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	19,345	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,043	6,277	2,553	9,873	8
9	SNF/PED					9
10	ICF	5,838	1,782		7,620	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,881	8,059	2,553	17,493	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.93%

D. How many bed-hold days during this year were paid by the Department?
NONE (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)

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 12/01/1953

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 26 and days of care provided 2,553

Medicare Intermediary NATIONAL GOVERNMENT 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 Fiscal Year: 11/30

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

Facility Name & ID Numbe RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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	167,285	5,115	5,086	177,486		177,486		177,486			1
2	Food Purchase		86,864		86,864		86,864	(122)	86,742			2
3	Housekeeping	144,763	15,797		160,560		160,560		160,560			3
4	Laundry	105,578	10,976		116,554		116,554	(70,008)	46,546			4
5	Heat and Other Utilities			147,634	147,634		147,634		147,634			5
6	Maintenance	64,099	19,317	75,101	158,517		158,517		158,517			6
7	Other (specify):*											7
8	TOTAL General Services	481,725	138,069	227,821	847,615		847,615	(70,130)	777,485			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	925,621	1,865	2,112	929,598		929,598		929,598			10
10a	Therapy											10a
11	Activities	56,693			56,693		56,693		56,693			11
12	Social Services	32,459			32,459		32,459		32,459			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,014,773	1,865	5,712	1,022,350		1,022,350		1,022,350			16
	C. General Administratior											
17	Administrative	104,380			104,380		104,380		104,380			17
18	Directors Fees											18
19	Professional Services			40,290	40,290		40,290		40,290			19
20	Dues, Fees, Subscriptions & Promotions			12,252	12,252		12,252	(3,506)	8,746			20
21	Clerical & General Office Expenses	44,903	17,445	35,540	97,888		97,888	(21,400)	76,488			21
22	Employee Benefits & Payroll Taxes			502,258	502,258		502,258		502,258			22
23	Inservice Training & Educatior											23
24	Travel and Seminar			7,669	7,669		7,669		7,669			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			98,524	98,524		98,524		98,524			26
27	Other (specify):*											27
28	TOTAL General Administration	149,283	17,445	696,533	863,261		863,261	(24,906)	838,355			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,645,781	157,379	930,066	2,733,226		2,733,226	(95,036)	2,638,190			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $100

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassificat

Facility Name & ID Numbe RANDOPH COUNTY CARE CENTER #0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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			98,987	98,987		98,987		98,987			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			879	879		879		879			35
36	Other (specify):*											36
37	**TOTAL Ownership**			99,866	99,866		99,866		99,866			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,714	340,260	430,974		430,974		430,974			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,750	54,750		54,750		54,750			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		90,714	395,010	485,724		485,724		485,724			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,645,781	248,093	1,424,942	3,318,816		3,318,816	(95,036)	3,223,780			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 Numbe RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning 12/01/2009 Ending: 11/30/2010

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

	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 Program:				3
4	Non-Patient Meals	(122)	2		4
5	Telephone, TV & Radio in Resident Room:				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(70,008)	4		8
9	Non-Straightline Depreciatior				9
10	Interest and Other Investment Incom				10
11	Discounts, Allowances, Rebates & Refund:				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	(21,400)	21		24
25	Fund Raising, Advertising and Promotiona	(3,506)	20		25
26	Income Taxes and Illinois Persona 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)	$ (95,036)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in th 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 Organizatior 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))	$ (95,036)		37

*These costs are only allowable if they are necessary to meet minimu licensing standards. Attach a schedule detailing the items include on these lines.

C. Are the following expenses included in Sections A to D of pages and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassificatio (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

RANDOPH COUNTY CARE CENTER

ID# 0000497

Report Period Beginning: 12/01/2009

Ending: 11/30/2010

	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 RANDOPH COUNTY CARE CENTER **#** 0000497 **Report Period Beginning:** 12/01/2009 **Ending:** 11/30/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(122)	0	0	0	0	0	0	0	0	0	0	(122)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(70,008)	0	0	0	0	0	0	0	0	0	0	(70,008)	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**	(70,130)	0	0	0	0	0	0	0	0	0	0	(70,130)	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	(3,506)	0	0	0	0	0	0	0	0	0	0	(3,506)	20
21	Clerical & General Office Expenses	(21,400)	0	0	0	0	0	0	0	0	0	0	(21,400)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(24,906)	0	0	0	0	0	0	0	0	0	0	(24,906)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(95,036)	0	0	0	0	0	0	0	0	0	0	(95,036)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 **Report Period Beginning:** 12/01/2009 **Ending:** 11/30/2010

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (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	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(95,036)	0	0	0	0	0	0	0	0	0	0	(95,036)	45

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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

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

1 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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column 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								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 RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 1/30/2010

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
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						$	$		$	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					$	$		$	25

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	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. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. (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 Numbe RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning 12/01/2009 Ending: 11/30/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(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:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of a application for real estate tax exemption unless the building is rented from a for-profit enti**
   This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RANDOPH COUNTY CARE CENTER COUNTY RANDOLPH

FACILITY IDPH LICENSE NUMBER 0000497

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,648 B. General Construction Type: Exterior BRICK Frame CONCRETE & STEEL Number of Stories 2

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	NURSING HOME	217,800	1950	$ 10,000	1
2					2
3	TOTALS	217,800		$ 10,000	3

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	52		1953	1953	$ 440,000	$	30	$	$	$ 440,000	4
5	48		1959	1959	326,191		30			326,191	5
6											6
7											7
8											8
	Improvement Type**										
9	GENERAL			1978	670,977		30			670,977	9
10	GENERAL			1979	1,546,599		30			1,546,599	10
11	ROOF IMPROVEMENT			1985	1,212		30			1,212	11
12	FUEL PUMP			1985	3,779		30			3,779	12
13	HEATING SYSTEM			1985	84,767		15			84,767	13
14	NURSE STATION ENTRY CONTROL			1986	8,369		15			8,369	14
15	DISPLAYCASE & NURSES STATION			1987	4,278		15			4,278	15
16	ROOF REPAIRS			1990	78,822	2,161	20	1,972	(189)	77,422	16
17	KITCHEN IMPROVEMENTS			1990	10,593		20	189	189	10,593	17
18	BOILER & PANIC BAR DOORS			1991	13,143		15			13,143	18
19	COMPRESSOR & SECURITY SYSTEM			1991	5,311		10			5,311	19
20	FLOORING			1993	87,160		15			87,160	20
21	ROOF REPLACEMENT			1993	102,602		15			102,602	21
22	PANIC BARS			1994	1,571		15			1,571	22
23	VINYL FLOOR COVERING & CEILING TILE			1994	5,234	262	20	262		4,323	23
24	CARPETING			1995	1,346		5			1,346	24
25	DOOR WITH SIDE LIGHT & PANIC BAR			1995	3,700	119	15	119		3,700	25
26	TELEPHONE SYSTEM			1995	28,740	1,437	20	1,437		22,274	26
27	NURSE CALL SYSTEM			1995	6,776		10			6,776	27
28	CARPETING			1996	2,932		5			2,932	28
29	ROOF TOP A/C COMPRESSORS			1997	2,476	165	15	165		2,228	29
30	REPLACE WINDOWS y ERECT ENTRANCE			1998	361,996	18,100	20	18,100		226,250	30
31	AIR COND SYSTEM			1999	179,160	11,944	15	11,944		137,356	31
32	MINI-KITCHEN SINK			1999	960	48	20	48		552	32
33	TV ANTENNA SYSTEM			1999	1,792	90	20	90		1,035	33
34	DOOR MONITOR SYSTEM			1999	8,358		5			8,358	34
35	GENERATROR FUEL TANK			1999	9,875	494	20	494		5,680	35
36	COMPUTER WIRING			2001	3,050	305	10	305		2,898	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	35 TON ROOFTOP A/C	2001	$ 9,547	$ 636	15	$ 636	$	$ 6,042	37
38	REPLACE FLUID COOLER	2001	4,520	301	15	301		2,860	38
39	COMPLETED FLUID COOLER	2002	59,932	3,995	15	3,995		35,955	39
40	BOILER REPAIRS	2002	2,786	280	10	280		2,379	40
41	KEY ACCESS	2003	2,285	229	10	229		1,717	41
42	VINYL FLOOR-GROUND FLOOR	2003	55,872	5,587	10	5,587		41,903	42
43	RESUFACE KITCHEN & DINING FLOORS	2003	5,903	590	10	590		4,425	43
44	REPLACE KITCHEN DRAINS	2003	18,459	738	25	738		4,797	44
45	ROOFTOP A/C	2004	6,722	448	15	448		2,912	45
46	]RENOVATE KITCHEN	2004	54,962	3,664	15	3,664		23,816	46
47	COMPRESSOR FOR 8.5 A/C	2004	3,288	219	15	219		1,424	47
48	HGAS LINE	2004	2,009	100	20	100		650	48
49	HANDICAP SHOWER & WHEELCHAIR WASHER	2004	13,269	663	20	663		4,310	49
50	TWO COMPRESSORS FOR A/C	2004	6,875	458	15	458		2,977	50
51	FOUR EXHAAUST SYSTEMS	2004	4,433	296	15	296		1,924	51
52	SEWER LINE REPAIR	2005	3,291	165	20	165		907	52
53	STORAGE SHED	2005	1,150	77	15	77		423	53
54	TILE FLOORING	2006	2,871	191	15	191		860	54
55	CONGOLIUM FLOORING	2006	8,463	564	15	564		2,538	55
56	FLOOR TILE	2007	8,350	557	15	557		1,949	56
57	SEWERAGE EHECTOR	2008	5,938	297	20	297		742	57
58	SPRINKLER	2008	8,700	435	20	435		1,087	58
59	SEWER SYSTEM REPAIR	2008	8,972	449	20	449		673	59
60	FLOORING & UTILITY ROOM	2009	131,992	8,799	15	8,799		13,199	60
61	REPLACE CANOPE	2009	21,838	1,092	20	1,092		1,517	61
62	FLOORING & UTILITY ROOM	2010	2,337	78	15	78		78	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,456,533	$ 66,033		$ 66,033	$	$ 3,971,746	70

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

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 386,236	$ 30,747	$ 30,747	$	12.56	$ 173,559	71
72	Current Year Purchases	25,125	2,207	2,207		5.7	2,207	72
73	Fully Depreciated Assets	799,683					799,683	73
74								74
75	TOTALS	$ 1,211,044	$ 32,954	$ 32,954	$		$ 975,449	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$ 46,654	$	$	$		$ 46,654	76
77										77
78										78
79										79
80	TOTALS			$ 46,654	$	$	$		$ 46,654	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,724,231	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 98,987	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 98,987	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)	$ 4,993,849	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 RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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 [X] NO

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 879 Description: DISHWASHER
(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 RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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.

   WE ONLY HIRE TRAINED AIDES

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 RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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	39/3	hrs	$	1,899	$ 143,858	$	1,899	$ 143,858	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		393	35,593		393	35,593	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		2,055	149,080		2,055	149,080	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				71,991		71,991	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): MEDICAL SUPPLIES	39/2					18,723		18,723	12
13	Other (specify): LAB & XRAY FEES	39/2				11,729			11,729	13
14	TOTAL			$	4,347	$ 340,260	$ 90,714	4,347	$ 430,974	14

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

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2010 (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	$ 32,878	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable Patients (less allowance (62,300))	715,479		3
4	Supply Inventory (priced a COST)	8,400		4
5	Short-Term Investments	4,161,089		5
6	Prepaid Insurance	109,976		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)**	$ 5,027,822	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	175,660		11
12	Long-Term Investments			12
13	Land	10,000		13
14	Buildings, at Historical Cost	4,464,688		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	1,249,541		16
17	Accumulated Depreciation (book methods	(4,993,849)		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)**	$ 906,040	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,933,862	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 381,790	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,395		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,789		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,120		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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 429,094	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 429,094	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,504,768	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,933,862	$	48

***(See instructions.)**

Facility Name & ID Numbe RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning 12/01/2009 Ending: 11/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,673,053	1
2	Restatements (describe)		2
3	AUDITORS ADJUSTMENT FOR INTEREST ON CD.S	15,309	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,688,362	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43	(183,594)	7
8	Aquisitions of Pooled Companie		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purpose		12
13	Dividends Paid or Other Distributions to Owner	( )	13
14	Donated Property, Plant, and Equipmen		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (183,594)	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)**	$ 5,504,768	24 *

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

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,078,100	1
2	Discounts and Allowances for all Levels	(76,217)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,001,883	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	276	13
14	Non-Patient Meals	122	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	70,008	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 70,406	23
	D. Non-Operating Revenue		
24	Contributions	6,173	24
25	Interest and Other Investment Income**	56,760	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 62,933	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)**	$ 3,135,222	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	847,615	31
32	Health Care	1,022,350	32
33	General Administration	863,261	33
	B. Capital Expense		
34	Ownership	99,866	34
	C. Ancillary Expense		
35	Special Cost Centers	430,974	35
36	Provider Participation Fee	54,750	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,318,816	40
41	**Income before Income Taxes (line 30 minus line 40)****	(183,594)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (183,594)	43

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

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

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

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

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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	2,000	2,160	$ 57,456	$ 26.60	1
2	Assistant Director of Nursing	1,095	1,151	20,679	17.97	2
3	Registered Nurses	2,585	2,800	52,998	18.93	3
4	Licensed Practical Nurses	11,720	12,772	187,287	14.66	4
5	CNAs & Orderlies	46,264	50,286	587,814	11.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,320	4,400	56,693	12.88	10
11	Social Service Workers	2,677	2,706	32,459	12.00	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,160	24,764	11.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,164	13,552	142,522	10.52	15
16	Dishwashers					16
17	Maintenance Workers	4,320	4,368	64,099	14.67	17
18	Housekeepers	11,048	13,030	144,763	11.11	18
19	Laundry	8,806	9,877	105,578	10.69	19
20	Administrator	2,080	2,656	102,130	38.45	20
21	Assistant Administrator	80	80	2,250	28.13	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,240	3,336	44,903	13.46	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	1,477	1,742	19,386	11.13	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,876	127,076	$ 1,645,781 *	$ 12.95	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	104	$ 5,086	1/3	35
36	Medical Director	48	3,600	9/3	36
37	Medical Records Consultant	16	899	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	600	10/3	39
40	Physical Therapy Consultant	6	337	10/3	40
41	Occupational Therapy Consultant	2	135	10/3	41
42	Respiratory Therapy Consultant	0			42
43	Speech Therapy Consultant	3	135	10/3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) purchacing group		6	10/3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	203	$ 10,798		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)		$ none		53

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ELIZABETH DILDAY	ADMINISTRATOR	NONE	$ 102,130
KENNETH SLAVINS	ASSIST ADMIN	NONE	2,250
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,380

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
JAMESTOWN MANAGEMENT	ACCOUNTING	$ 34,800
GALLOP & JOHNSON	LEGAL	5,490
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 40,290

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,226
Unemployment Compensation Insurance	1,790
FICA Taxes	125,902
Employee Health Insurance	175,906
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	140,969
AFCME SUPPORT	1,305
DRUG TESTS & PHYSICALS	514
GIFTS& PARTIES	4,145
VACCINATIONS	1,501
TOTAL (agree to Schedule V, line 22, col.8)	$ 502,258

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	283
Health Care Worker Background Check	200
(Indicate # of checks performed 10)	
Patient Background Checks 53	1,050
LSN DUES	4,537
VARIOUS DUES	665
ADVERTISING	3,506
SUBSCRIPTION	21
Less: Public Relations Expense	3,506
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,758

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
LOCAL MILAGE	3,187
Seminar Expense	
SCHEDULED	4,482
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,669

**See instructions.

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2009 Ending: 11/30/2010

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number RANDOPH COUNTY CARE CENTER # 0000497 **Report Period Beginning:** 12/01/2009 **Ending:** 11/30/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **YES**

(2) Are there any dues to nursing home associations included on the cost repor **YES**
If YES, give association name and amount **LSN 4537**

(3) Did the nursing home make political contributions or payments to a politic 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 t 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 **5.7**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **NONE** Line

(7) Have all costs reported on this form been determined using accounting procedur 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 f 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 ove

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme during this cost report period. $ **54,750**
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 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 t the Department, in addition to the daily rate, been properly classifie 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 f 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, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benef on Schedule V. $ **NONE** Has any meal income been offset agains related costs? **YES** Indicate the amount $ **122**

(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 f residents? **NO** If YES, please indicate the amount of income earned from such program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients **10**
d. Have vehicle usage logs been maintained **YES**
e. Are all vehicles stored at the nursing home during the night and all oth times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjuste out of the cost report? **YES**
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. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm **YES**
Firm Name: **SCHORB & SCHMERSAHL**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of servic performed been attached to this cost report **YES**
Attach invoices and a summary of services for all architect and appraisal fee