

		FOR BHF USE					

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**2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)**

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

<p>I. IDPH License ID Number: <u>0000497</u></p> <p>Facility Name: <u>RANDOLPH COUNTY CARE CENTER</u></p> <p>Address: <u>310 W. BELMONT</u> <u>SPARTA</u> <u>62286</u> Number City Zip Code</p> <p>County: <u>RANDOLPH</u></p> <p>Telephone Number: <u>618-443-4351</u> Fax # <u>618-443-2700</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1953</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input checked="" type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input checked="" type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>ROGER W. BAGLEY</u> Telephone Number: <u>618-549-8331</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/2010</u> to <u>11/30/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1473 751 1663 954">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>ROGER W. BAGLEY</u> (Title) <u>CONTROLLER</u></td> </tr> <tr> <td data-bbox="1473 954 1663 1242">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () () Fax # () ()</td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>ROGER W. BAGLEY</u> (Title) <u>CONTROLLER</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () () Fax # () ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County																											
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	<input type="checkbox"/> "Sub-S" Corp.	_____																											
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>ROGER W. BAGLEY</u> (Title) <u>CONTROLLER</u>																												
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () () Fax # () ()																												

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER

0000497 Report Period Beginning: 12/01/2010 Ending: 11/30/2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	1,575	7,512	3,142	12,229	8	
9	SNF/PED					9	
10	ICF	5,758	1,472		7,230	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	7,333	8,984	3,142	19,459	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.31%

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

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

I. On what date did you start providing long term care at this location?
Date started 12/01/1953

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 26 and days of care provided 3,142

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number **RANDOLPH COUNTY CARE CENTER** # **0000497** Report Period Beginning: **12/01/2010** Ending: **11/30/2011**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	179,220	7,038	5,174	191,432		191,432		191,432		1
2	Food Purchase		101,809		101,809		101,809	(117)	101,692		2
3	Housekeeping	152,509	18,831		171,340		171,340		171,340		3
4	Laundry	110,485	10,577		121,062		121,062	(73,740)	47,322		4
5	Heat and Other Utilities			141,643	141,643		141,643		141,643		5
6	Maintenance	66,868	29,272	93,891	190,031		190,031		190,031		6
7	Other (specify):*										7
8	TOTAL General Services	509,082	167,527	240,708	917,317		917,317	(73,857)	843,460		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	979,285	5,661	1,762	986,708		986,708		986,708		10
10a	Therapy										10a
11	Activities	58,157			58,157		58,157		58,157		11
12	Social Services	31,344			31,344		31,344		31,344		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,068,786	5,661	5,362	1,079,809		1,079,809		1,079,809		16
	C. General Administration										
17	Administrative	91,509			91,509		91,509		91,509		17
18	Directors Fees										18
19	Professional Services			100,924	100,924		100,924		100,924		19
20	Dues, Fees, Subscriptions & Promotions			12,866	12,866		12,866	(5,881)	6,985		20
21	Clerical & General Office Expenses	56,755	18,811	73,174	148,740		148,740	(63,181)	85,559		21
22	Employee Benefits & Payroll Taxes			536,759	536,759		536,759		536,759		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,933	4,933		4,933		4,933		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			107,244	107,244		107,244		107,244		26
27	Other (specify):*										27
28	TOTAL General Administration	148,264	18,811	835,900	1,002,975		1,002,975	(69,062)	933,913		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,726,132	191,999	1,081,970	3,000,101		3,000,101	(142,919)	2,857,182		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			99,306	99,306		99,306	619	99,925			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			1,039	1,039		1,039		1,039			35
36	Other (specify):*											36
37	TOTAL Ownership			100,345	100,345		100,345	619	100,964			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		132,369	478,633	611,002		611,002		611,002			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		132,369	533,383	665,752		665,752		665,752			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,726,132	324,368	1,715,698	3,766,198		3,766,198	(142,300)	3,623,898			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(117)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(73,740)	4		8
9	Non-Straightline Depreciation	619	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,181)	21		24
25	Fund Raising, Advertising and Promotional	(5,881)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,300)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (142,300)		37

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

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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

BHF USE ONLY							
48		49		50		51	52

RANDOLPH COUNTY CARE CENTER

ID# 0000497

Report Period Beginning: 12/01/2010

Ending: 11/30/2011

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 RANDOLPH COUNTY CARE CENTER# 0000497

Report Period Beginning:

12/01/2010

Ending:

11/30/2011

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(117)	0	0	0	0	0	0	0	0	0	0	(117)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(73,740)	0	0	0	0	0	0	0	0	0	0	(73,740)	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	(73,857)	0	0	0	0	0	0	0	0	0	0	(73,857)	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	(5,881)	0	0	0	0	0	0	0	0	0	0	(5,881)	20
21	Clerical & General Office Expenses	(63,181)	0	0	0	0	0	0	0	0	0	0	(63,181)	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	(69,062)	0	0	0	0	0	0	0	0	0	0	(69,062)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(142,919)	0	0	0	0	0	0	0	0	0	0	(142,919)	29

STATE OF ILLINOIS

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER# 0000497

Report Period Beginning:

12/01/2010 Ending:

Summary B

11/30/2011

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	619	0	0	0	0	0	0	0	0	0	0	619	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	619	0	0	0	0	0	0	0	0	0	0	619	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(142,300)	0	0	0	0	0	0	0	0	0	0	(142,300)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number **RANDOLPH COUNTY CARE CENTER** # **0000497** Report Period Beginning: **12/01/2010** Ending: **11/30/2011**

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2010 Ending: 1/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

RANDOLPH COUNTY CARE CENTER

0000497

Report Period Beginning:

12/01/2010

Ending:

11/30/2011

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

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2010 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 2011 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:	2006	_____	8	FOR BHF USE ONLY		
	2007	_____	9			
	2008	_____	10			
	2009	_____	11			
	2010	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2010 \$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RANDOLPH 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 2010 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 2010.

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

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 RANDOLPH COUNTY CARE CENTER

0000497

Report Period Beginning:

12/01/2010 Ending:

11/30/2011

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>217,800</u>	<u>1950</u>	<u>\$ 10,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	217,800		\$ 10,000	3

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER

0000497

Report Period Beginning:

12/01/2010 Ending:

11/30/2011

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	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	780	20	1,400	620	78,822	16
17	KITCHEN IMPROVEMENTS		1990		10,593		20			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		4,585	23
24	CARPETING		1995		1,346		5			1,346	24
25	DOOR WITH SIDE LIGHT & PANIC BARSD		1995		3,700		15			3,700	25
26	TELEPHONE SYSTEM		1995		28,740	1,437	20	1,437		23,711	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		2,393	29
30	REPLACE WINDOWS & ERECT ENTRANCE		1998		361,996	18,100	20	18,100		244,350	30
31	AIR COND SYSTEM		1999		179,160	11,944	15	11,944		149,300	31
32	MINI-KITCHEN SINK		1999		960	48	20	48		600	32
33	TV ANTENNA SYSTEM		1999		1,792	90	20	90		1,125	33
34	DOOR MONITOR SYSTEM		1999		8,358		5			8,358	34
35	GENERATOR FUEL TANK		1999		9,875	494	20	494		6,174	35
36	COMPUTER WIRING		2001		3,050	153	10	152	(1)	3,050	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 RANDOLPH COUNTY CARE CENTER

0000497

Report Period Beginning:

12/01/2010 Ending: 11/30/2011

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	35 TON ROOFTOP A/C	2001	\$ 9,547	\$ 636	15	\$ 636	\$	\$ 6,678	37
38	REPLACE FLUID COOLER	2001	4,520	301	15	301		3,161	38
39	COMPLETED FLUID COOLER	2002	59,932	3,995	15	3,995		39,950	39
40	BOILER REPAIRS	2002	2,786	280	10	280		2,659	40
41	KEY ACCESS	2003	2,285	229	10	229		1,946	41
42	VINYL FLOOR GROUND FLOOR	2003	55,872	5,587	10	5,587		47,490	42
43	RESURFACE KITCHEN & DINING FLOORS	2003	5,903	590	10	590		5,015	43
44	REPLACE KITCHEN DRAINS	2003	18,459	738	25	738		5,535	44
45	ROOFTOP A/C	2004	6,722	448	15	448		3,360	45
46	RENOVATE KITCHEN	2004	54,962	3,664	15	3,664		27,480	46
47	COMPRESSOR FOR 8.5 TON A/C	2004	3,288	219	15	219		1,643	47
48	H GAS LINE	2004	2,009	100	20	100		750	48
49	HANDICAP SHOWER & WHEELCHAIR WASHER	2004	13,269	663	20	663		4,973	49
50	TWO COMPRESSORS FOR A/C	2004	6,875	458	15	458		3,435	50
51	FOUR EXHAUST SYSTEMS	2004	4,433	296	15	296		2,220	51
52	SEWER LINE REPAIR	2005	3,291	165	20	165		1,072	52
53	STORAGE SHED	2005	1,150	77	15	77		500	53
54	TILE FLOORING	2006	2,871	191	15	191		1,051	54
55	CONGOLIUM FLOORING	2006	8,463	564	15	564		3,102	55
56	FLOOR TILE	2007	8,350	557	15	557		2,506	56
57	SEWERAGE EJECTOR	2008	5,938	297	20	297		1,039	57
58	SPRINKLER	2008	8,700	435	20	435		1,522	58
59	SEWER SYSTEM REPAIR	2008	8,972	449	20	449		1,122	59
60	FLOORING & UTILITY ROOM	2009	131,992	8,799	15	8,799		21,998	60
61	REPLACE CANOPE	2009	21,838	1,092	20	1,092		2,609	61
62	FLOORING & UTILITY ROOM	2010	2,337	156	15	156		234	62
63	CONCRETE DRIVEWAY REDO	2011	9,680	242	20	242		242	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,466,213	\$ 64,701		\$ 65,320	\$ 619	\$ 4,037,066	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 391,032	\$ 31,389	\$ 31,389	\$	12.56	\$ 186,826	71
72	Current Year Purchases	75,323	3,216	3,216		11.7	3,216	72
73	Fully Depreciated Assets	820,012					820,012	73
74								74
75	TOTALS	\$ 1,286,367	\$ 34,605	\$ 34,605	\$		\$ 1,010,054	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	TRANSPORT RESIDENTS	2002 CHEVY BUS	Apr-02	\$ 46,654	\$	\$	\$	4	\$ 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)	\$ 5,809,234	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,306	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 99,925	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 619	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,093,774	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 1,039 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

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. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><u>WE ONLY HIRE TRAINED AIDES</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	\$	2,655	\$ 190,833	\$	2,655	\$ 190,833	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		675	72,552		675	72,552	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		2,848	197,927		2,848	197,927	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				109,913		109,913	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): MEDICAL SUPPLIES	39/2					22,456		22,456	12
13	Other (specify): LAB & XRAY FEES	39/3/				17,321			17,321	13
14	TOTAL			\$	6,178	\$ 478,633	\$ 132,369	6,178	\$ 611,002	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **11/30/2011**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 63,875	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,500)	1,169,128		3
4	Supply Inventory (priced at COST)	8,400		4
5	Short-Term Investments	3,909,305		5
6	Prepaid Insurance	74,160		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)	\$ 5,224,868	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable	172,803		11
12	Long-Term Investments			12
13	Land	10,000		13
14	Buildings, at Historical Cost	4,474,370		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,324,861		16
17	Accumulated Depreciation (book methods)	(5,093,155)		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)	\$ 888,879	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,113,747	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 412,559	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,572		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	48,805		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,779		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)	\$ 469,715	\$	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)	\$ 469,715	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,644,032	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,113,747	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,504,768	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,504,768	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	139,264	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)	\$ 139,264	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)	\$ 5,644,032	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **RANDOLPH COUNTY CARE CENTER**# **0000497**Report Period Beginning: **12/01/2010**Ending: **11/30/2011**

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,563,853	1
2	Discounts and Allowances for all Levels	224,918	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,788,771	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	372	13
14	Non-Patient Meals	117	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	73,740	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 74,229	23
D. Non-Operating Revenue			
24	Contributions	8,776	24
25	Interest and Other Investment Income***	33,056	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 41,832	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	630	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 630	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,905,462	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	917,317	31
32	Health Care	1,079,809	32
33	General Administration	1,002,975	33
B. Capital Expense			
34	Ownership	100,345	34
C. Ancillary Expense			
35	Special Cost Centers	611,002	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)*	\$ 3,766,198	40
41	Income before Income Taxes (line 30 minus line 40)**	139,264	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 139,264	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 **RANDOLPH COUNTY CARE CENTER**

0000497

Report Period Beginning: **12/01/2010**

Ending:

11/30/2011

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,730	2,890	\$ 74,130	\$ 25.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,418	3,712	72,565	19.55	3
4	Licensed Practical Nurses	10,258	11,242	181,372	16.13	4
5	CNAs & Orderlies	46,004	50,111	630,698	12.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,160	4,240	58,157	13.72	9
10	Activity Assistants					10
11	Social Service Workers	2,587	2,678	31,344	11.70	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,108	24,515	11.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,105	13,517	154,705	11.45	15
16	Dishwashers					16
17	Maintenance Workers	4,073	4,362	66,868	15.33	17
18	Housekeepers	11,234	13,066	152,509	11.67	18
19	Laundry	8,602	9,776	110,485	11.30	19
20	Administrator	2,465	2,621	91,509	34.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,996	4,092	56,755	13.87	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	1,429	1,704	20,520	12.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,141	126,119	\$ 1,726,132 *	\$ 13.69	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	96	\$ 5,174	1-3	35
36	Medical Director	48	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	601	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	168	\$ 9,375		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
KENNETH SLAVINS	ADMINISTRATOR	NONE	\$ 91,509	Workers' Compensation Insurance	\$ 47,244	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	165	
				FICA Taxes	131,892	Health Care Worker Background Check		
				Employee Health Insurance	185,805	(Indicate # of checks performed 14)	355	
				Employee Meals		Patient Background Checks	57 1,075	
				Illinois Municipal Retirement Fund (IMRF)*	155,633	LSN DUES	3,096	
				AWARDS & BONUSES	7,905	FIRE MARSHALL & HEALTH DEPT	300	
				VACCINATIONS	2,281	ADVERTISING	5,881	
				GIFTS & PARTIES	1,213	NEWSPAPER SUBSCRIPTIONS	1,542	
				DRUG TESTS	559	FINGER PRINTING	452	
				AFSCME SUPPORT	1,595	Less: Public Relations Expense	()	
				LICENSES & NAME BADGES	2,632	Non-allowable advertising	(5,881)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 91,509				\$ 536,759		\$ 6,985		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
							SCHEDULED	3,435
							Seminar Expense	
							SCHEDULED	1,498
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$				\$			\$ 4,933	
C. Professional Services								
Vendor/Payee	Type	Amount						
JAMESTOWN MANAGEMENT	ACCOUNTING	\$ 34,800						
GALLOP & JOHNSON	LEGAL	2,834						
DUANE MORRIS LLP	LEGAL	63,290						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 100,924								

* Attach copy of IMRF notifications

**See instructions.

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 report? YES
If YES, give association name and amount. LSN 3096
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 12YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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 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. \$ NONE Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 10
 - d. Have vehicle usage logs been maintained? YES
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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 out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.