

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>312 WEST BELMONT</u> <u>SPARTA</u> <u>62286</u> <small>Number City Zip Code</small></p> <p>County: <u>RANDOLPH</u></p> <p>Telephone Number: <u>618-443-4351</u> Fax # <u>618-453-2700</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 style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>ROGER BAGLEY</u> Telephone Number: <u>(618) 549-8331</u> <u>JAMESTOWN MANAGEMENT</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <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>12/01/2011</u> to <u>11/30/2012</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>ROGER W. BAGLEY</u> (Title) <u>CONTROLLER</u> </td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="right"> 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) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>ROGER W. BAGLEY</u> (Title) <u>CONTROLLER</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER

0000497 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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	17,202	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	19,398	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,252	9,193	2,959	14,404	8
9	SNF/PED					9
10	ICF	4,306	1,573		5,879	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,558	10,766	2,959	20,283	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.42%

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)
NONE

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 2,959

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	200,307	6,595	5,487	212,389		212,389	212,389		1	
2	Food Purchase		111,296		111,296		111,296	(692)	110,604	2	
3	Housekeeping	160,529	17,806		178,335		178,335		178,335	3	
4	Laundry	117,146	12,541		129,687		129,687	(71,812)	57,875	4	
5	Heat and Other Utilities			142,124	142,124		142,124		142,124	5	
6	Maintenance	62,382	25,835	68,868	157,085		157,085		157,085	6	
7	Other (specify):*									7	
8	TOTAL General Services	540,364	174,073	216,479	930,916		930,916	(72,504)	858,412	8	
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600	9	
10	Nursing and Medical Records	1,073,071	4,503	1,499	1,079,073		1,079,073		1,079,073	10	
10a	Therapy									10a	
11	Activities	60,158			60,158		60,158		60,158	11	
12	Social Services	35,180			35,180		35,180		35,180	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,168,409	4,503	5,099	1,178,011		1,178,011		1,178,011	16	
	C. General Administration										
17	Administrative	73,825			73,825		73,825		73,825	17	
18	Directors Fees									18	
19	Professional Services			45,853	45,853		45,853		45,853	19	
20	Dues, Fees, Subscriptions & Promotions			13,965	13,965		13,965	(5,818)	8,147	20	
21	Clerical & General Office Expenses	56,792	20,014	16,063	92,869		92,869		92,869	21	
22	Employee Benefits & Payroll Taxes			640,377	640,377		640,377		640,377	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			4,478	4,478		4,478		4,478	24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			98,250	98,250		98,250		98,250	26	
27	Other (specify):*									27	
28	TOTAL General Administration	130,617	20,014	818,986	969,617		969,617	(5,818)	963,799	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,839,390	198,590	1,040,564	3,078,544		3,078,544	(78,322)	3,000,222	29	

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

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

Facility Name & ID Number

RANDOLPH COUNTY CARE CENTER

#0000497

Report Period Beginning:

12/01/2011

Ending:

11/30/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			101,652	101,652		101,652	101,652				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			20,999	20,999		20,999	20,999				35
36	Other (specify):*											36
37	TOTAL Ownership			122,651	122,651		122,651	122,651				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,603	554,671	681,274		681,274	681,274				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			158,818	158,818		158,818	158,818				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		126,603	713,489	840,092		840,092	840,092				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,839,390	325,193	1,876,704	4,041,287		4,041,287	(78,322)	3,962,965			45

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

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER

0000497

Report Period Beginning: 12/01/2011

Ending: 11/30/2012

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	(692)	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	(71,812)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,818)	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)	\$ (78,322)		\$	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)	\$ (78,322)		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: 12/01/2011

Ending: 11/30/2012

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

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:

12/01/2011

Ending:

11/30/2012

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	(692)	0	0	0	0	0	0	0	0	0	0	(692)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(71,812)	0	0	0	0	0	0	0	0	0	0	(71,812)	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	(72,504)	0	0	0	0	0	0	0	0	0	0	(72,504)	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	(5,818)	0	0	0	0	0	0	0	0	0	0	(5,818)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(5,818)	0	0	0	0	0	0	0	0	0	0	(5,818)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(78,322)	0	0	0	0	0	0	0	0	0	0	(78,322)	29

STATE OF ILLINOIS

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER# 0000497

Report Period Beginning:

12/01/2011 Ending:

Summary B

11/30/2012

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(78,322)	0	0	0	0	0	0	0	0	0	0	(78,322)	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: 12/01/2011 Ending: 11/30/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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29								29
30								30

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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:

12/01/2011

Ending: 1/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	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:

12/01/2011

Ending:

11/30/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2011 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 2012 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:	2007 _____	8	FOR BHF USE ONLY			
	2008 _____	9				
	2009 _____	10			13 FROM R. E. TAX STATEMENT FOR 2011 \$	13
	2010 _____	11			14 PLUS APPEAL COST FROM LINE 5 \$	14
	2011 _____	12			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.

2011 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 2011 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 2011.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,648 B. General Construction Type: Exterior BRICK Frame CONCRETE & STEE 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:

A. Land.

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

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER

0000497

Report Period Beginning:

12/01/2011

Ending:

11/30/2012

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	\$		\$		\$ 440,000	4
5	48		1959	1959	326,191					326,191	5
6											6
7											7
8											8
	Improvement Type**										
9		GENERAL		1978	670,977					670,977	9
10		GENERAL		1979	1,546,599					1,546,599	10
11		ROOF REPROVEMENT		1985	1,212					1,212	11
12		FUEL PUMP		1985	3,779					3,779	12
13		HEATING SYSTEM		1985	84,767					84,767	13
14		NURSE STATION ENTRY CONTROL		1986	8,369					8,369	14
15		DISPLAY CASE & NURSES STATION		1987	4,278					4,278	15
16		ROOF REPAIRS		1990	78,822					78,822	16
17		KITCHEN IMPROVEMENTS		1990	10,593					10,593	17
18		BOILER & PANIC BAR DOORS		1991	13,143					13,143	18
19		COMPRESSOR & SECURITY SYSTEM		1991	5,311					5,311	19
20		FLOORING		1993	87,160					87,160	20
21		ROOF REPLACEMENT		1993	102,602					102,602	21
22		PANIC BARS		1994	1,571					1,571	22
23		VINYL FLOOR COVERING & CEILING TILE		1994	5,234	262		262		4,847	23
24		CARPETING		1995	1,346					1,346	24
25		DOOR WITH SIDE LIGHT & PANIC BARS		1995	3,700					3,700	25
26		TELEPHONE SYSTEM		1995	28,740	1,437		1,437		25,148	26
27		NURSE CALL SYSTEM		1995	6,776					6,776	27
28		CARPETING		1996	2,932					2,932	28
29		ROOF TOP A/C COMPRESSORS		1997	2,476	83		83		2,476	29
30		REPLACE WINDOWS & ERECT ENTRANCE		1998	361,996	18,100		18,100		262,450	30
31		AIR COND SYSTEM		1999	179,160	11,944		11,944		161,244	31
32		MINI-KITCHEN SIND		1999	960	48		48		648	32
33		TV ANTENNA		1999	1,792	90		90		1,215	33
34		DOOR MONITOR SYSTEM		1999	8,358					8,358	34
35		GENERATOR FUEL TANK		1999	9,875	494		494		6,668	35
36		COMPUTER WIRING		2001	3,050					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:

12/01/2011 Ending: 11/30/2012

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	\$	\$ 7,314	37
38	REPLACE FLUID COOLER	2001	4,520	301	15	301		3,462	38
39	COMPLETED FLUID COOLER	2002	59,932	3,995	15	3,995		43,945	39
40	BOILER REPAIRS	2002	2,786	127	10	127		2,786	40
41	KEY ACCESS	2003	2,285	229	10	229		2,175	41
42	VINYL FLOOR GROUND FLOOR	2003	55,872	5,587	10	5,587		53,077	42
43	RESURFACE KITCHEN & DINING FLOORS	2003	5,903	590	10	590		5,605	43
44	REPLACE KITCHEN DRAINS	2003	18,459	738	25	738		6,273	44
45	ROOFTOP A/C	2004	6,722	448	15	448		3,808	45
46	RENOVATE KITCHEN	2004	54,962	3,664	15	3,664		31,144	46
47	COMPRESSOR FOR 8.5 TON A/C	2004	3,288	219	15	219		1,862	47
48	H GAS LINE	2004	2,009	100	20	100		850	48
49	HANDICAP SHOWER & WHEELCHAIR WASHER	2004	13,269	663	20	663		5,636	49
50	TWO COMPRESSORS FOR A/C	2004	6,875	458	15	458		3,893	50
51	FOUR EXHAUST SYSTEMS	2004	4,433	296	15	296		2,516	51
52	SEWER LINE REPAIR	2005	3,291	165	20	165		1,237	52
53	STORAGE SHED	2005	1,150	77	15	77		577	53
54	TILE FLOORING	2006	2,871	191	15	191		1,242	54
55	CONGOLIUM FLOORING	2006	8,463	564	15	564		3,666	55
56	FLOOR TILE	2007	8,350	557	15	557		3,063	56
57	SEWERAGE EJECTOR	2008	5,938	297	20	297		1,336	57
58	SPRINKLER	2008	8,700	435	20	435		1,957	58
59	SEWER SYSTEM REPAIR	2008	8,972	449	20	449		1,571	59
60	FLOORING & UTILITY ROOM	2009	131,992	8,799	15	8,799		30,797	60
61	REPLACE CANOPE	2009	21,838	1,092	20	1,092		3,701	61
62	FLOORING & UTILITY ROOM	2010	2,337	156	15	156		390	62
63	CONCRETE DRIVEWAY REDO	2011	9,680	484	20	484		726	63
64	SMOKE ALARM SYSTEM	2011	50,923	2,546	10	2,546		2,546	64
65	WINDOW IN MASONRY WALL	2012	2,300	77	15	77		77	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,519,436	\$ 66,398		\$ 66,398	\$	\$ 4,103,464	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	\$ 400,284	\$ 34,323	\$ 34,323	\$		\$ 157,675	71
72	Current Year Purchases	16,444	931	931		10 YR	931	72
73	Fully Depreciated Assets	886,083					886,083	73
74								74
75	TOTALS	\$ 1,302,811	\$ 35,254	\$ 35,254	\$		\$ 1,044,689	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	2-Apr	\$ 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)	\$ 5,878,901	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,652	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,652	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)	\$ 5,194,807	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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: \$ 20,999 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER # 0000497 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3	hrs	\$	3,173	\$ 223,809	\$	3,173	\$ 223,809	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		657	63,092		657	63,092	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		3,742	251,830		3,742	251,830	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 prescripts				91,605		91,605	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): MEDICAL SUPPLIES	39/2				15,940	34,998		50,938	12
13	Other (specify): XRAY & LAB FEES	39/3								13
14	TOTAL			\$	7,572	\$ 554,671	\$ 126,603	7,572	\$ 681,274	14

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

Facility Name & ID Number **RANDOLPH COUNTY CARE CENTER**

0000497

Report Period Beginning: **12/01/2011**

Ending: **11/30/2012**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **11/30/2012** (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	\$ 95,570	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	888,909		3
4	Supply Inventory (priced at COST)	8,400		4
5	Short-Term Investments	3,558,731		5
6	Prepaid Insurance	52,143		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)	\$ 4,603,753	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000		13
14	Buildings, at Historical Cost	4,527,593		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,341,305		16
17	Accumulated Depreciation (book methods)	(5,194,807)		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)	\$ 684,091	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,287,844	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 322,324	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,177		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,449		30
31	Accrued Taxes Payable (excluding real estate taxes)	46,689		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)	\$ 434,639	\$	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)	\$ 434,639	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,853,205	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,287,844	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,644,032	1
2	Restatements (describe):		2
3	2011 OCCUPIED TAX	(42,514)	3
4	2011 PUBLIC AID INCREASE	38,659	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,640,177	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(244,357)	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)	\$ (244,357)	17
	B. Transfers (Itemize):		
18	TRANSFER TO COUNTY	(671,928)	18
19	CONTRIBUTION BY COUNTY	129,313	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (542,615)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,853,205	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,840,623	1
2	Discounts and Allowances for all Levels	(148,610)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,692,013	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	420	13
14	Non-Patient Meals	692	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	71,812	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 72,924	23
D. Non-Operating Revenue			
24	Contributions	6,189	24
25	Interest and Other Investment Income***	25,804	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31,993	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)	\$ 3,796,930	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	930,916	31
32	Health Care	1,178,011	32
33	General Administration	969,617	33
B. Capital Expense			
34	Ownership	122,651	34
C. Ancillary Expense			
35	Special Cost Centers	681,274	35
36	Provider Participation Fee	158,818	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,041,287	40
41	Income before Income Taxes (line 30 minus line 40)**	(244,357)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (244,357)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 801,353	44
45	Private Pay - Net Inpatient Revenue	1,227,349	45
46	Medicare - Net Inpatient Revenue	1,663,311	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,692,013	49

* 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: **12/01/2011**

Ending: **11/30/2012**

11/30/2012

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,928	2,080	\$ 54,962	\$ 26.42	1
2	Assistant Director of Nursing	1,227	1,227	16,913	13.78	2
3	Registered Nurses	3,762	4,114	83,689	20.34	3
4	Licensed Practical Nurses	11,863	13,021	191,908	14.74	4
5	CNAs & Orderlies	49,114	53,700	704,915	13.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,160	4,231	60,158	14.22	9
10	Activity Assistants					10
11	Social Service Workers	2,576	2,672	35,180	13.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,214	17,002	200,307	11.78	15
16	Dishwashers					16
17	Maintenance Workers	4,082	4,162	62,382	14.99	17
18	Housekeepers	11,066	13,281	160,529	12.09	18
19	Laundry	8,825	10,053	117,146	11.65	19
20	Administrator	2,080	2,080	73,825	35.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,799	3,799	56,792	14.95	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	1,428	1,671	20,684	12.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,124	133,093	\$ 1,839,390 *	\$ 13.82	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	93	\$ 5,487	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				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)	181	\$ 10,586		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			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
KENNETH SLAVINS	ADMINISTRATOR	NONE	\$ 73,825	Workers' Compensation Insurance	\$ 51,593	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	555		
				FICA Taxes	140,301	Health Care Worker Background Check	356		
				Employee Health Insurance	245,718	(Indicate # of checks performed <u>16</u>)			
				Employee Meals		Patient Background Checks <u>57</u>	1,142		
				Illinois Municipal Retirement Fund (IMRF)*	193,484	YELLOW PAGE & PROMOTIONS	5,818		
				VACCINATIONS	1,515	SUBSCRIPTIONS & DUES	1,502		
				AWARDS & BONUSES	5,522	BOILER & FIRE MARSHAL FEES	290		
				DRUG TESTS	707	LSN DUES	2,088		
				PERSONAL SUPPORT	1,537	FINGER PRINTS	224		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	(5,818)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,825	TOTAL (agree to Schedule V, line 22, col.8)		\$ 640,377	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 8,147
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description				Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							SCHEDULE ATTACHED	2,383	
							Seminar Expense		
							SCHEDULE ATTACHED	2,095	
							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)		\$ 4,478
C. Professional Services			Amount						
Vendor/Payee	Type			Description	Line #	Amount	Description	Amount	
JAMESTOWN MANAGEMENT	ACCOUNTING	\$ 31,900							
DUANE MORRIS LLP	LEGAL	13,953							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 45,853	TOTAL		\$			

* Attach copy of IMRF notifications

**See instructions.

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

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

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 2088
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (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. \$ 158,818
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? 100
 - d. Have vehicle usage logs been maintained? YES
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
 - g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: SCHORB & SCHMERSAHL, LLCC
- (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.