FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0000497

Facility Name: Randolph County Care Center

Address: 312 West Belmont (Number) Sparta (City) 62286 (Zip Code)

County: Randolph

Telephone Number: 618-443-4351 **Fax #** 618-453-2700

HFS ID Number:

Date of Initial License for Current Owners: 1953

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** 630-361-2868
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/15 to 11/30/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Ken Slavens
(Title) Administrator

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) Larry Templin, Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP, P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	47	Skilled (SNF)	47	17,202	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,748	2,377	2,113	7,238	8
9	SNF/PED					9
10	ICF	7,519	8,777		16,296	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,267	11,154	2,113	23,534	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.30%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 12/1/1953

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 1,983

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 11/30/16 Fiscal Year: 11/30/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	231,431	10,391	5,711	247,533		247,533		247,533			1
2	Food Purchase		141,409		141,409		141,409	(280)	141,129			2
3	Housekeeping	172,499	19,108		191,607		191,607		191,607			3
4	Laundry	144,484	12,286		156,770		156,770	(56,247)	100,523			4
5	Heat and Other Utilities			164,451	164,451		164,451		164,451			5
6	Maintenance	72,010	14,992	47,364	134,366		134,366		134,366			6
7	Other (specify):*			4,790	4,790		4,790		4,790			7
8	TOTAL General Services	620,424	198,186	222,316	1,040,926		1,040,926	(56,527)	984,399			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,349,598	32,691	9,260	1,391,549		1,391,549		1,391,549			10
10a	Therapy											10a
11	Activities	49,288			49,288		49,288		49,288			11
12	Social Services	41,572			41,572		41,572		41,572			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,440,458	32,691	15,260	1,488,409		1,488,409		1,488,409			16
	C. General Administration											
17	Administrative	84,443			84,443		84,443		84,443			17
18	Directors Fees											18
19	Professional Services			68,229	68,229		68,229		68,229			19
20	Dues, Fees, Subscriptions & Promotions			13,075	13,075		13,075	(50)	13,025			20
21	Clerical & General Office Expenses	87,822	9,246	13,519	110,587		110,587	(170)	110,417			21
22	Employee Benefits & Payroll Taxes			864,611	864,611		864,611	(13,194)	851,417			22
23	Inservice Training & Education			326	326		326		326			23
24	Travel and Seminar			2,750	2,750		2,750		2,750			24
25	Other Admin. Staff Transportation			2,988	2,988		2,988		2,988			25
26	Insurance-Prop.Liab.Malpractice			75,011	75,011		75,011		75,011			26
27	Other (specify):*											27
28	TOTAL General Administration	172,265	9,246	1,040,509	1,222,020		1,222,020	(13,414)	1,208,606			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,233,147	240,123	1,278,085	3,751,355		3,751,355	(69,941)	3,681,414			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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: 12/1/15 Ending: 11/30/16

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			86,485	86,485		86,485	(1,663)	84,822			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			15,336	15,336		15,336		15,336			35
36	Other (specify):* Mort Ins											36
37	**TOTAL Ownership**			101,821	101,821		101,821	(1,663)	100,158			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,822	621,753	662,575		662,575		662,575			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			184,936	184,936		184,936		184,936			42
43	Other (specify):* See Att Sch 4A			84,461	84,461		84,461	(60,401)	24,060			43
44	**TOTAL Special Cost Centers**		40,822	891,150	931,972		931,972	(60,401)	871,571			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,233,147	280,945	2,271,056	4,785,148		4,785,148	(132,005)	4,653,143			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Randolph County Care Center

Period Beginning 12/1/15
Period End 11/30/16

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			24,060	24,060		24,060		24,060			
	Radiology Expenses				0		0		0			
	Non-Allowable Expenses			60,401	60,401		60,401	(60,401)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	0	0	84,461	84,461	0	84,461	(60,401)	24,060			

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(280)	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	(69,441)	Var		8
9	Non-Straightline Depreciation	(1,663)	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	(100)	21		17
18	Fines and Penalties	(50)	20		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	(50,754)	43		24
25	Fund Raising, Advertising and Promotional	(9,647)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(70)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (132,005)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (132,005)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Randolph County Care Center

ID# 0000497

Report Period Beginning: 12/1/15

Ending: 11/30/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income Against Expense	$ (70)	21	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**	(70)		49

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

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
Randolph County						
See Page 6-Supp for list of Board members		None		None		

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 [X] NO

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

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	Dr. Marc Kiehna	0						1
2	David Holder	0						2
3	Ronnie White	0						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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

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	Note: No services are provided to the nursing home by Board members or their relatives										5
6	See Page 6-Supp for a list of Board members										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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2015**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

N/A - County facility does not pay real estate taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2015 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 Ken Slavens

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,648 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 1

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

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

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

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

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

None

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

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

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	217,800	1950	$ 10,000	1
2					2
3	TOTALS	217,800		$ 10,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	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	Display Case & Nurse Station			1987	4,278		15			4,278	15
16	Roof Repairs			1990	78,822		20			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		20			5,234	23
24	Carpeting			1995	1,346		5			1,346	24
25	Door with Side Light and Panic Bars			1995	3,700		15			3,700	25
26	Telephone System			1995	28,740		20			28,740	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		15			2,476	29
30	Replace Windows and Erect Entrance			1998	361,996	18,100	20	18,100		334,850	30
31	Air Cond System			1999	179,160		15			179,160	31
32	Mini-Kitchen Sink			1999	960	48	20	48		840	32
33	TV Antenna System			1999	1,792	90	20	90		1,575	33
34	Door Monitor System			1999	8,358		5			8,358	34
35	Generator Fuel Tank			1999	9,875	494	20	494		8,644	35
36	Computer Wiring			2001	3,050		10			3,050	36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	35 Ton Rooftop A/C	2001	9,547	325	15	325	$	$ 9,547	37
38	Replace Fluid Cooler	2001	4,520	155	15	155		4,520	38
39	Completed Fluid Cooler	2002	59,932	3,995	15	3,995		59,925	39
40	Boiler Repairs	2002	2,786		10			2,786	40
41	Key Access	2003	2,285		10			2,285	41
42	Vinyl Floor Ground Floor	2003	55,872		10			55,872	42
43	Resurface Kitchen & Dining Floors	2003	5,903		10			5,903	43
44	Replace Kitchen Drains	2003	18,459	738	25	738		9,225	44
45	Rooftop A/C	2004	6,722	448	15	448		5,600	45
46	Renovate Kitchen	2004	54,962	3,664	15	3,664		45,800	46
47	Compressor for 8.5 Ton A/C	2004	3,288	219	15	219		2,738	47
48	Hgas Line	2004	2,009	100	20	100		1,250	48
49	Handicap Shower and Wheelchair Washer	2004	13,269	663	20	663		8,288	49
50	Two Compressors for A/C	2004	6,875	458	15	458		5,725	50
51	Four Exhaust Systems	2004	4,433	296	15	296		3,700	51
52	Sewer Line Repair	2005	3,291	165	20	165		1,897	52
53	Storage Shed	2005	1,150	77	15	77		885	53
54	Tile Flooring	2006	2,871	191	15	191		2,006	54
55	Lanolium Flooring	2006	8,463	564	15	564		5,922	55
56	Floor Tile	2007	8,350	557	15	557		5,291	56
57	Sewage Ejector	2008	5,938	297	20	297		2,524	57
58	Sprinkler	2008	8,700	435	20	435		3,697	58
59	Sewer System Repair	2008	8,972	449	20	449		3,367	59
60	Flooring & Utility Room	2009	131,992	8,799	15	8,799		65,999	60
61	Replace Canopy	2009	21,838	1,092	20	1,092		8,069	61
62	Flooring & Utility Room	2010	2,337	156	15	156		1,014	62
63	Concrete Driveway Redo	2011	9,680	484	20	484		2,662	63
64	Smoke Alarm System	2011	50,923	5,092	10	5,092		22,914	64
65	Window Installed in Masonry Wall	2012	2,300	153	15	153		689	65
66	Rooftop Package Unit 15 Ton	2013	15,384	1,026	15	1,026		3,591	66
67	Repair Cooling Tower	2013	22,615	2,262	10	2,262		7,917	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,557,435	$ 51,592		$ 51,592	$	$ 4,334,663	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,557,435	$ 51,592		$ 51,592	$	$ 4,334,663	1
2									2
3	Install Door Restrictor	2014	5,963	994	15	398	(596)	995	3
4	Install New Backflow	2014	6,300	1,050	15	420	(630)	1,050	4
5	Repair Cooling Tower	2014	4,375	729	15	292	(437)	730	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	TOTAL (lines 1 thru 33)		$ 4,574,073	$ 54,365		$ 52,702	$ (1,663)	$ 4,337,438	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

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	$ 458,468	$ 32,120	$ 32,120	$	3-15 yrs	$ 292,290	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	893,855					893,855	73
74								74
75	TOTALS	$ 1,352,323	$ 32,120	$ 32,120	$		$ 1,186,145	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	2002	$ 46,654	$	$	$	5	$ 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)	$ 5,983,050	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 86,485	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 84,822	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,663)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,570,237	85	

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

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

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 15,336 Description: Dish Machine $1,019, Medical Equipment $5,115, Phone System $9,202
(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	N/A				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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	4,041	$ 290,956	$	4,041	$ 290,956	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		467	49,932		467	49,932	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,617	280,865		5,617	280,865	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				40,822		40,822	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	10,125	$ 621,753	$ 40,822	10,125	$ 662,575	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.

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Randolph County Care Center **#** 0000497 **Report Period Beginning:** 12/1/15 **Ending:** 11/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/16 **(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	$ 95,111	$ 95,111	1
2	Cash-Patient Deposits	2,623	2,623	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 483,752)	941,237	941,237	3
4	Supply Inventory (priced at Cost)	8,400	8,400	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,853	1,853	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,049,224	$ 1,049,224	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,310,900	1,310,900	12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	4,574,073	4,574,073	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,398,977	1,398,977	16
17	Accumulated Depreciation (book methods)	(5,570,790)	(5,570,237)	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)**	$ 1,723,160	$ 1,723,713	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,772,384	$ 2,772,937	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 135,181	$ 135,181	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,623	2,623	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	287,081	287,081	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,538	7,538	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Randolph County	1,020,997	1,020,997	36
37	See Attached Schedule 17A	144,329	144,329	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,597,749	$ 1,597,749	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)**	$ 1,597,749	$ 1,597,749	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,174,635	$ 1,175,188	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,772,384	$ 2,772,937	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Randolph County Care Center

Period 12/1/15
Period 11/30/16

Schedule 17A

XV. Balance Sheet
Line 23 Other

	Operating	After Consolidation
Accrued IMRF	(2,593)	(2,593)
Garnishments	(2,386)	(2,386)
Due to Public Aid	127,201	127,201
Employee Benefit Fund	4,972	4,972
Accrued Bed Taxes	17,135	17,135
TOTAL	144,329	144,329

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,734,838	1
2	Restatements (describe):		2
3	**Bad Debt Expense**	(520,222)	3
4	**IMRF Expense**	(239,656)	4
5	**Rounding**	1	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,974,961	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(125,326)	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)**	$ (125,326)	17
	B. Transfers (Itemize):		
18	**Permanent Transfer to Randolph County**	(675,000)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (675,000)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,174,635	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,163,894	1
2	Discounts and Allowances for all Levels	652,452	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,816,346	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	626,485	6
7	Oxygen	625	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 627,110	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	280	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	13	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,696	21
22	Laundry	69,441	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 85,430	23
	D. Non-Operating Revenue		
24	Contributions	7,226	24
25	Interest and Other Investment Income***	8,172	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,398	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	70	28
28a	Inter-Governmental Transfer	115,468	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 115,538	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,659,822	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,040,926	31
32	Health Care	1,488,409	32
33	General Administration	1,222,020	33
	B. Capital Expense		
34	Ownership	101,821	34
	C. Ancillary Expense		
35	Special Cost Centers	747,036	35
36	Provider Participation Fee	184,936	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,785,148	40
41	**Income before Income Taxes (line 30 minus line 40)****	(125,326)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (125,326)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,296,365	44
45	Private Pay - Net Inpatient Revenue	1,497,067	45
46	Medicare - Net Inpatient Revenue	947,058	46
47	Other-(specify) Managed Care	75,856	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,816,346	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,344	$ 67,353	$ 28.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,545	5,743	145,617	25.36	3
4	Licensed Practical Nurses	9,386	10,603	240,715	22.70	4
5	CNAs & Orderlies	46,377	52,069	869,719	16.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,290	4,425	49,288	11.14	10
11	Social Service Workers	2,558	2,558	41,572	16.25	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,531	15,454	231,431	14.98	15
16	Dishwashers					16
17	Maintenance Workers	3,906	4,215	72,010	17.08	17
18	Housekeepers	10,518	12,619	172,499	13.67	18
19	Laundry	8,744	10,043	144,484	14.39	19
20	Administrator	2,088	2,328	84,443	36.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,609	5,970	87,822	14.71	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	1,663	1,913	26,194	13.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,295	130,284	$ 2,233,147 *	$ 17.14	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 5,711	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	3 Visits	715	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,678	L10, C3	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)		$ 14,104		49

C. CONTRACT NURSES

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

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ken Slavens	Administrator	None	$ 84,443
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,443

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Templin Healthcare Accounting	Accounting	$ 20,108
Wescom Solutions	Computer Services (Admin Porti	10,301
Ability Network	Computer Services	4,693
Terrill Consulting Services	Billing Consultant	15,300
ADP	Payroll Processing	17,198
Benefit Planning Consultants	Benefit Plan Consultants	629
Note: 40% ($6,867) of Wescom Solutions was already reclassified to Line 10		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 68,229

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,438
Unemployment Compensation Insurance	
FICA Taxes	170,602
Employee Health Insurance	315,725
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	299,787
Vaccinations, Physicals, Drug Tests	1,668
Personal Support	1,827
Christmas Gifts	9,620
Life Insurance	3,126
Other Employee Benefits	818
Less: Laundry Income Offset	(13,194)
TOTAL (agree to Schedule V, line 22, col.8)	$ 851,417

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,974
Advertising: Employee Recruitment	1,166
Health Care Worker Background Check	
(Indicate # of checks performed 3)	105
Patient Background Checks 47	940
Leading Age/LSN	3,769
Various Licenses/Permits	1,294
Various Subscriptions	777
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,025

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,935
Seminar Expense	815
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,750

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/15 Ending: 11/30/16

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. **3,769 LSN/Leading Age**

(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? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,323** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **184,936**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **280**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% line 14**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Schorb & Schmersahl, LLC**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees