

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0000497 Facility Name: RANDOLPH COUNTY CARE CENTER Address: 310 W. BELMONT SPARTA 62286 Number City Zip Code County: RANDOLPH Telephone Number: 618-443-4351 Fax #: 618-443-2700 HFS ID Number: Date of Initial License for Current Owners: 1953 Type of Ownership: VOLUNTARY, NON-PROFIT Charitable Corp. Trust IRS Exemption Code PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other X GOVERNMENTAL State X County Other In the event there are further questions about this report, please contact: Name: ROGER W. BAGLEY Telephone Number: 618-549-8331 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/2010 to 11/30/2011 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) (Type or Print Name) ROGER W. BAGLEY (Title) CONTROLLER Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) () Fax # () MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number RANDOLPH COUNTY CARE CENTER

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>47</u>	Skilled (SNF)	<u>47</u>	<u>17,155</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>53</u>	Intermediate (ICF)	<u>53</u>	<u>19,345</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>100</u>	TOTALS	<u>100</u>	<u>36,500</u>	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	<u>1,575</u>	<u>7,512</u>	<u>3,142</u>	<u>12,229</u>	8
9	SNF/PED					9
10	ICF	<u>5,758</u>	<u>1,472</u>		<u>7,230</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,333</u>	<u>8,984</u>	<u>3,142</u>	<u>19,459</u>	14

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

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

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

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

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

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

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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.

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

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

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

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			99,306	99,306		99,306	619	99,925			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,039	1,039		1,039		1,039			35
36	Other (specify):*											36
37	TOTAL Ownership			100,345	100,345		100,345	619	100,964			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		132,369	478,633	611,002		611,002		611,002			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,750	54,750		54,750		54,750			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		132,369	533,383	665,752		665,752		665,752			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,726,132	324,368	1,715,698	3,766,198		3,766,198	(142,300)	3,623,898			45

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

VI. ADJUSTMENT DETAIL

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

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

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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (142,300)		37

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

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

		1 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

STATE OF ILLINOIS
RANDOLPH COUNTY CARE CENTER

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

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

Summary A

11/30/2011

[illegible]

Summary B

11/30/2011

[illegible]

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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
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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

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

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

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

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006		8		
	2007		9		
	2008		10		
	2009		11		
	2010		12		

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

FACILITY NAME	<u>RANDOLPH COUNTY CARE CENTER</u>	COUNTY	<u>RANDOLPH</u>
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CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>

1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$	\$

B. Real Estate Tax Cost Allocations

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,648

B. General Construction Type: Exterior brick Frame concrete & steel Number of Stories 2

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

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

0000497

Report Period Beginning:

12/01/2010

Ending:

11/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	52		1953	1953	\$ 440,000	\$	30	\$		\$ 440,000	4
5	48		1959	1959	326,191		30			326,191	5
6											6
7											7
8											8
	Improvement Type**										
9	GENERAL			1978	670,977		30			670,977	9
10	GENERAL			1979	1,546,599		30			1,546,599	10
11	ROOF IMPROVEMENT			1985	1,212		30			1,212	11
12	FUEL PUMP			1985	3,779		30			3,779	12
13	HEATING SYSTEM			1985	84,767		15			84,767	13
14	NURSE STATION ENTRY CONTROL			1986	8,369		15			8,369	14
15	DISPLAYCASE & NURSES STATION			1987	4,278		15			4,278	15
16	ROOF REPAIRS			1990	78,822	780	20	1,400	620	78,822	16
17	KITCHEN IMPROVEMENTS			1990	10,593		20			10,593	17
18	BOILER & PANIC BAR DOORS			1991	13,143		15			13,143	18
19	COMPRESSOR & SECURITY SYSTEM			1991	5,311		10			5,311	19
20	FLOORING			1993	87,160		15			87,160	20
21	ROOF REPLACEMENT			1993	102,602		15			102,602	21
22	PANIC BARS			1994	1,571		15			1,571	22
23	VINYL FLOOR COVERING & CEILING TILE			1994	5,234	262	20	262		4,585	23
24	CARPETING			1995	1,346		5			1,346	24
25	DOOR WITH SIDE LIGHT & PANIC BARSD			1995	3,700		15			3,700	25
26	TELEPHONE SYSTEM			1995	28,740	1,437	20	1,437		23,711	26
27	NURSE CALL SYSTEM			1995	6,776		10			6,776	27
28	CARPETING			1996	2,932		5			2,932	28
29	ROOF TOP A/C COMPRESSORS			1997	2,476	165	15	165		2,393	29
30	REPLACE WINDOWS & ERECT ENTRANCE			1998	361,996	18,100	20	18,100		244,350	30
31	AIR COND SYSTEM			1999	179,160	11,944	15	11,944		149,300	31
32	MINI-KITCHEN SINK			1999	960	48	20	48		600	32
33	TV ANTENNA SYSTEM			1999	1,792	90	20	90		1,125	33
34	DOOR MONITOR SYSTEM			1999	8,358		5			8,358	34
35	GENERATOR FUEL TANK			1999	9,875	494	20	494		6,174	35
36	COMPUTER WIRING			2001	3,050	153	10	152	(1)	3,050	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number RANDOLPH COUNTY CARE CENTER

0000497

Report Period Beginning:

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

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

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

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)									
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6		
71	Purchased in Prior Years	\$ 391,032	\$ 31,389	\$ 31,389	\$	12.56	\$ 186,826	71	
72	Current Year Purchases	75,323	3,216	3,216		11.7	3,216	72	
73	Fully Depreciated Assets	820,012					820,012	73	
74								74	
75	TOTALS	\$ 1,286,367	\$ 34,605	\$ 34,605	\$		\$ 1,010,054	75	

D. Vehicle Costs. (See instructions.)*										
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	TRANSPORT RESIDENTS	2002 CHEVY BUS	Apr-02	\$ 46,654	\$	\$	\$	4	\$ 46,654	76
77										77
78										78
79										79
80	TOTALS			\$ 46,654	\$	\$	\$		\$ 46,654	80

E. Summary of Care-Related Assets					1	2	
		Reference				Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)				\$ 5,809,234	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$ 99,306	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$ 99,925	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$ 619	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$ 5,093,774	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress			
	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☒ NO

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

**

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

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO
16. Rental Amount for movable equipment: \$1,039
- Description: DISHWASHER

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

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

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

☐

☐

WE ONLY HIRE TRAINED AIDES

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)	\$			

- (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.

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	

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39/3	hrs	\$	2,655	\$ 190,833	\$	2,655	\$ 190,833	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		675	72,552		675	72,552	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		2,848	197,927		2,848	197,927	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				109,913		109,913	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): MEDICAL SUPPLIES	39/2					22,456		22,456	12
13	Other (specify): LAB & XRAY FEES	39/3/				17,321			17,321	13
14	TOTAL			\$	6,178	\$ 478,633	\$ 132,369	6,178	\$ 611,002	14

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

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	\$ 63,875	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,500)	1,169,128		3
4	Supply Inventory (priced at COST)	8,400		4
5	Short-Term Investments	3,909,305		5
6	Prepaid Insurance	74,160		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,224,868	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	172,803		11
12	Long-Term Investments			12
13	Land	10,000		13
14	Buildings, at Historical Cost	4,474,370		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,324,861		16
17	Accumulated Depreciation (book methods)	(5,093,155)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 888,879	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,113,747	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 412,559	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,572		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	48,805		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,779		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 469,715	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 469,715	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,644,032	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,113,747	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,504,768	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,504,768	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	139,264	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 139,264	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,644,032	24 *

* This must agree with page 17, line 47.

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

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,563,853	1
2	Discounts and Allowances for all Levels	224,918	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,788,771	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	372	13
14	Non-Patient Meals	117	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	73,740	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 74,229	23
	D. Non-Operating Revenue		
24	Contributions	8,776	24
25	Interest and Other Investment Income***	33,056	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 41,832	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING	630	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 630	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,905,462	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	917,317	31
32	Health Care	1,079,809	32
33	General Administration	1,002,975	33
	B. Capital Expense		
34	Ownership	100,345	34
	C. Ancillary Expense		
35	Special Cost Centers	611,002	35
36	Provider Participation Fee	54,750	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,766,198	40
41	Income before Income Taxes (line 30 minus line 40)**	139,264	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 139,264	43

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,730	2,890	\$ 74,130	\$ 25.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,418	3,712	72,565	19.55	3
4	Licensed Practical Nurses	10,258	11,242	181,372	16.13	4
5	CNAs & Orderlies	46,004	50,111	630,698	12.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,160	4,240	58,157	13.72	9
10	Activity Assistants					10
11	Social Service Workers	2,587	2,678	31,344	11.70	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,108	24,515	11.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,105	13,517	154,705	11.45	15
16	Dishwashers					16
17	Maintenance Workers	4,073	4,362	66,868	15.33	17
18	Housekeepers	11,234	13,066	152,509	11.67	18
19	Laundry	8,602	9,776	110,485	11.30	19
20	Administrator	2,465	2,621	91,509	34.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,996	4,092	56,755	13.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,429	1,704	20,520	12.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,141	126,119	\$ 1,726,132 *	\$ 13.69	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96	\$ 5,174	1-3	35
36	Medical Director	48	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	601	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	168	\$ 9,375		49

C. CONTRACT NURSES

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

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

** See instructions.

XIX. SUPPORT SCHEDULES

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

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. LSN 3096

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 12YR

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

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

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,750
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 10
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ NONE

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

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

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