

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0000497</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Randolph County Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/19</u> to <u>11/30/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>312 West Belmont</u> <u>Sparta</u> <u>62286</u>																									
Number City Zip Code																									
County: <u>Randolph</u>																									
Telephone Number: <u>618-443-4351</u> Fax # <u>618-453-2700</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Larry Templin</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 326, Plainfield, IL 60544-0326</u></td></tr><tr><td>(Telephone) <u>(630) 361-2868</u> Fax # ()</td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	Paid Preparer	(Print Name and Title) <u>Larry Templin</u> <u>Partner</u>	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 326, Plainfield, IL 60544-0326</u>	(Telephone) <u>(630) 361-2868</u> 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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	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																								
Date of Initial License for Current Owners: <u>1953</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☒ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☒ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☒ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☒ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ "Sub-S" Corp.																								
	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Larry Templin</u> Telephone Number: <u>630-361-2868</u>																									
Email Address: _____																									
SEE ACCOUNTANTS' PREPARATION REPORT																									

Facility Name & ID Number Randolph County Care Center

0000497 Report Period Beginning: 12/1/19 Ending: 11/30/20

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>17,202</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>53</u>	Intermediate (ICF)	<u>53</u>	<u>19,398</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>36,600</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>445</u>	<u>859</u>	<u>2,462</u>	<u>3,766</u>	8
9	SNF/PED					9
10	ICF	<u>6,488</u>	<u>7,605</u>	<u>210</u>	<u>14,303</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,933</u>	<u>8,464</u>	<u>2,672</u>	<u>18,069</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 49.37 %

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 for Hospitals

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 ☒ 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 ☒

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 ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 26 and days of care provided 2,462

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

Tax Year: 11/30/20 Fiscal Year: 11/30/20
* 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: **12/1/19** Ending: **11/30/20**
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	225,607	15,828	6,008	247,443		247,443		247,443			1
2	Food Purchase		124,855		124,855		124,855	(135)	124,720			2
3	Housekeeping	150,051	16,047		166,098		166,098		166,098			3
4	Laundry	169,412	10,153		179,565		179,565	(49,261)	130,304			4
5	Heat and Other Utilities			120,382	120,382		120,382		120,382			5
6	Maintenance	70,383	16,224	64,222	150,829		150,829		150,829			6
7	Other (specify):* Waste Disposal			6,450	6,450		6,450		6,450			7
8	TOTAL General Services	615,453	183,107	197,062	995,622		995,622	(49,396)	946,226			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,327,252	39,278	15,469	1,381,999		1,381,999		1,381,999			10
10a	Therapy											10a
11	Activities	69,304			69,304		69,304		69,304			11
12	Social Services	43,899			43,899		43,899		43,899			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,440,455	39,278	21,469	1,501,202		1,501,202		1,501,202			16
	C. General Administration											
17	Administrative	67,863			67,863		67,863		67,863			17
18	Directors Fees											18
19	Professional Services			59,351	59,351		59,351		59,351			19
20	Dues, Fees, Subscriptions & Promotions			8,399	8,399		8,399		8,399			20
21	Clerical & General Office Expenses	88,628	7,987	12,687	109,302		109,302	(402)	108,900			21
22	Employee Benefits & Payroll Taxes			789,585	789,585		789,585	(10,814)	778,771			22
23	Inservice Training & Education											23
24	Travel and Seminar			410	410		410		410			24
25	Other Admin. Staff Transportation			1,849	1,849		1,849		1,849			25
26	Insurance-Prop.Liab.Malpractice			75,171	75,171		75,171		75,171			26
27	Other (specify):*											27
28	TOTAL General Administration	156,491	7,987	947,452	1,111,930		1,111,930	(11,216)	1,100,714			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,212,399	230,372	1,165,983	3,608,754		3,608,754	(60,612)	3,548,142			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.

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			64,447	64,447		64,447	2,590	67,037			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,430	10,430		10,430	(979)	9,451			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,868	20,868		20,868		20,868			35
36	Other (specify):*											36
37	TOTAL Ownership			95,745	95,745		95,745	1,611	97,356			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,774	425,777	481,551		481,551		481,551			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			154,818	154,818		154,818		154,818			42
43	Other (specify):* See Att Sch 4A			236,857	236,857		236,857	(220,391)	16,466			43
44	TOTAL Special Cost Centers		55,774	817,452	873,226		873,226	(220,391)	652,835			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,212,399	286,146	2,079,180	4,577,725		4,577,725	(279,392)	4,298,333			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 12/1/19
Period End 11/30/20

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			16,466	16,466		16,466		16,466			
	Radiology Expenses				0		0		0			
	Non-Allowable Expenses			220,842	220,842		220,842	(220,842)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	0	0	237,308	237,308	0	237,308	(220,842)	16,466			

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	(135)	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				8
9	Non-Straightline Depreciation	2,590	30		9
10	Interest and Other Investment Income	(979)	32		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	(2,200)	43		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	(213,859)	43		24
25	Fund Raising, Advertising and Promotional	(4,332)	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	(60,477)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (279,392)		\$	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))	\$ (279,392)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income Against Expense	\$ (402)	21	1
2	Offset Laundry Income Against Wages	(46,257)	4	2
3	Offset Laundry Income Against Employee Ben.	(10,814)	22	3
4	Offset Laundry Income Against Laundry Supplies	(3,004)	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
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(60,477)		49

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
See Page 6 - Supplemental		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		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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	Board of Directors:							1
2	Dr. Marc Kiehna	0						2
3	David Holder	0						3
4	Ronnie White	0						4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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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: 12/1/19 Ending: 11/30/20

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 - Supplemental 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

Ending: 11/30/20

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	USDA		X	Roof	Quarterly Int	8/19/19	\$ 242,000	242,000	5/1/39	0.0350	\$ 8,470	1	
2	USDA		X	Roof	Quarterly Int	8/19/19	56,000	56,000	5/1/39	0.0350	1,960	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 298,000	\$ 298,000			\$ 10,430	9	
	B. Non-Facility Related*												
10												10	
11								Interest Income offset			(979)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (979)	14	
15	TOTALS (line 9+line14)						\$ 298,000	\$ 298,000			\$ 9,451	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 Randolph County Care Center COUNTY Randolph
FACILITY IDPH LICENSE NUMBER 0000497
CONTACT PERSON REGARDING THIS REPORT Larry Templin
TELEPHONE (630) 361-2868 FAX #:

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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.)

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.

A. Square Feet: 54,648

B. General Construction Type: Exterior BrickFrame 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.(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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	217,800	1950	\$ 10,000	1
2					2
3	TOTALS			\$ 10,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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	Display Case & Nurse Station		1987		4,278		15			4,278	15
16	Roof Repairs		1990		78,822		20			79,469	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		20			361,996	30
31	Air Cond System		1999		179,160		15			179,160	31
32	Mini-Kitchen Sink		1999		960		20			960	32
33	TV Antenna System		1999		1,792		20			1,792	33
34	Door Monitor System		1999		8,358		5			8,358	34
35	Generator Fuel Tank		1999		9,875		20			9,875	35
36	Computer Wiring		2001		3,050		10			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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center

0000497

Report Period Beginning:

12/1/19

Ending:

11/30/20

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	\$	15	\$	\$	\$ 9,547	37
38	Replace Fluid Cooler	2001	4,520		15			4,520	38
39	Completed Fluid Cooler	2002	59,932		15			59,932	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		12,177	44
45	Rooftop A/C	2004	6,722		15	226	226	6,948	45
46	Renovate Kitchen	2004	54,962		15	1,834	1,834	56,796	46
47	Compressor for 8.5 Ton A/C	2004	3,288		15	112	112	3,400	47
48	Hgas Line	2004	2,009	100	20	100		1,650	48
49	Handicap Shower and Wheelchair Washer	2004	13,269	663	20	663		10,940	49
50	Two Compressors for A/C	2004	6,875		15	234	234	7,109	50
51	Four Exhaust Systems	2004	4,433		15	141	141	4,574	51
52	Sewer Line Repair	2005	3,291	165	20	165		2,557	52
53	Storage Shed	2005	1,150	34	15	77	43	1,193	53
54	Tile Flooring	2006	2,871	191	15	191		2,770	54
55	Lanolium Flooring	2006	8,463	564	15	564		8,178	55
56	Floor Tile	2007	8,350	557	15	557		7,519	56
57	Sewage Ejector	2008	5,938	297	20	297		3,712	57
58	Sprinkler	2008	8,700	435	20	435		5,437	58
59	Sewer System Repair	2008	8,972	449	20	449		5,163	59
60	Flooring & Utility Room	2009	131,992	8,799	15	8,799		101,195	60
61	Replace Canopy	2009	21,838	1,092	20	1,092		12,437	61
62	Flooring & Utility Room	2010	2,337	156	15	156		1,638	62
63	Concrete Driveway Redo	2011	9,680	484	20	484		4,598	63
64	Smoke Alarm System	2011	50,923	5,092	10	5,092		43,282	64
65	Window Installed in Masonry Wall	2012	2,300	153	15	153		1,301	65
66	Rooftop Package Unit 15 Ton	2013	15,384	1,026	15	1,026		7,695	66
67	Repair Cooling Tower	2013	22,615	2,262	10	2,262		16,965	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,557,435	\$ 23,257		\$ 25,847	\$ 2,590	\$ 4,472,495	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:

12/1/19

Ending:

11/30/20

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

1	2	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	\$ 23,257		\$ 25,847	\$ 2,590	\$ 4,472,495	1
2									2
3	Install Door Restrictor	2014	5,963	398	15	398		2,587	3
4	Install New Backflow	2014	6,300	419	15	419		2,727	4
5	Repair Cooling Tower	2014	4,375	292	15	292			5
6	Roof Repair	2016	11,000	733	15	733		2,565	6
7	Sealing of Smoke Partitions at Doors	2017	3,588	239	15	239		837	7
8	Wiring from Generator to Nurses Station	2017	3,169	211	15	211		739	8
9	Replaced Section of Cast Iron Pipe in Basement	2017	2,904	194	15	194		679	9
10	Walk in Cooler	2018	5,793	386	15	386		965	10
11	Replace Roof	2019	296,417	11,857	25	11,857		17,785	11
12	Water Heater--Boiler Room	2019	7,474	498	15	498		747	12
13	Install Heat Pump	2019	3,898	260	15	260		390	13
14	Install Console Unit for Nurses Station	2019	3,776	252	15	252		378	14
15	Air Conditioner	2019	10,911	727	15	727		1,091	15
16	Access Control System Installation	2019	5,432	362	15	362		543	16
17	Replaced Outside Sewer	2020	14,687	489	15	489		489	17
18	Installed New Bearing and Seal Assembly-Basement Hot Water Ci	2020	2,881	96	15	96		96	18
19	Chiller Repair	2020	3,083	103	15	103		103	19
20	Replaced Piping on Bilge Pumps	2020	6,885	230	15	230		230	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)		\$ 4,955,971	\$ 41,003		\$ 43,593	\$ 2,590	\$ 4,505,446	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 253,384	\$ 22,810	\$ 22,810	\$	3-15 yrs	\$ 172,027	71
72	Current Year Purchases	12,679	634	634		10 Yrs	634	72
73	Fully Depreciated Assets	1,120,202					1,120,202	73
74								74
75	TOTALS	\$ 1,386,265	\$ 23,444	\$ 23,444	\$		\$ 1,292,863	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
77									
78									
79									
80	TOTALS			\$ 46,654	\$	\$	\$		\$ 46,654

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)			\$	6,398,890
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	64,447
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	67,037
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	2,590
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	5,844,963

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		\$	\$	\$
87	N/A			
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93	N/A	
94		
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

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 20,868 Description: See Attached Schedule 14A
(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:

Randolph County Care Center

IDPH License ID Number:

0000497

Fiscal Year End:

11/30/20

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Medical Equipment Rental	7,238
Dish Machine	1,199
Telephone Equipment	12,431
Total - Line 16	20,868

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

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

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	\$	9,213	\$ 193,869	\$	9,213	\$ 193,869	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		854	47,304		854	47,304	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		8,954	184,604		8,954	184,604	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				55,774		55,774	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	19,021	\$ 425,777	\$ 55,774	19,021	\$ 481,551	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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 347,656	\$ 347,656	1
2	Cash-Patient Deposits	4,577	4,577	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 57,268)	841,493	841,493	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	(6,386)	(6,386)	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,195,740	\$ 1,195,740	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	291,202	291,202	12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	376,024	4,955,971	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,012,866	1,432,919	16
17	Accumulated Depreciation (book methods)	(5,844,177)	(5,844,963)	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)	\$ 845,915	\$ 845,129	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,041,655	\$ 2,040,869	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 49,151	\$ 49,151	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,577	4,577	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	276,379	276,379	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,629	8,629	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	<u>See Attached Schedule 17A</u>	3,284,563	3,284,563	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,623,299	\$ 3,623,299	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	298,000	298,000	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)	\$ 298,000	\$ 298,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,921,299	\$ 3,921,299	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,879,644)	\$ (1,880,430)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,041,655	\$ 2,040,869	48

Facility Name: Randolph County Care Center
IDPH License ID Number: 0000497
Fiscal Year End: 11/30/20

Schedule 17A

XV. Balance Sheet

Line 37 Other

	Operating	After Consolidation
Accrued IMRF	1,985	1,985
Deferred Pension Liability	2,668,297	2,668,297
Deferred Revenue	607,969	607,969
Employee Benefit Fund	7,433	7,433
Other Accrued Expenses	(1,121)	(1,121)
TOTAL	3,284,563	3,284,563

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,761,380)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,761,380)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(251,994)	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) Permanent Transfers	133,730	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (118,264)	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)	\$ (1,879,644)	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: 12/1/19

Ending: 11/30/20

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,679,555	1
2	Discounts and Allowances for all Levels	1,229,853	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,909,408	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	315,606	6
7	Oxygen	400	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 316,006	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	135	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	71	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,463	21
22	Laundry	60,075	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 68,744	23
	D. Non-Operating Revenue		
24	Contributions	3,470	24
25	Interest and Other Investment Income***	979	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,449	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	402	28
28a	Inter-Governmental Transfer	26,722	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 27,124	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,325,731	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	995,622	31
32	Health Care	1,501,202	32
33	General Administration	1,111,930	33
	B. Capital Expense		
34	Ownership	95,745	34
	C. Ancillary Expense		
35	Special Cost Centers	718,408	35
36	Provider Participation Fee	154,818	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,577,725	40
41	Income before Income Taxes (line 30 minus line 40)**	(251,994)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (251,994)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,257,418	44
45	Private Pay - Net Inpatient Revenue	1,267,170	45
46	Medicare - Net Inpatient Revenue	1,193,750	46
47	Other-(specify) <u>Managed Care</u>	191,070	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,909,408	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

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	660	730	\$ 16,930	\$ 23.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,845	4,118	118,843	28.86	3
4	Licensed Practical Nurses	14,359	16,358	370,172	22.63	4
5	CNAs & Orderlies	47,365	53,227	790,234	14.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,062	4,709	69,304	14.72	10
11	Social Service Workers	2,266	2,450	43,899	17.92	11
12	Dietician					12
13	Food Service Supervisor	1,723	2,076	30,852	14.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,180	14,432	194,755	13.49	15
16	Dishwashers					16
17	Maintenance Workers	3,832	4,144	70,383	16.98	17
18	Housekeepers	9,475	11,575	150,051	12.96	18
19	Laundry	9,925	11,476	169,412	14.76	19
20	Administrator	2,000	2,000	67,863	33.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,925	4,589	88,628	19.31	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	1,718	2,016	31,073	15.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	118,335	133,900	\$ 2,212,399 *	\$ 16.52	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,008	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,362	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)		\$ 13,370		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	7	357	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	7	\$ 357		53

SEE ACCOUNTANTS' PREPARATION REPORT

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
Michelle Cato	Administrator	0	\$ 67,863	Workers' Compensation Insurance		\$ 60,770	IDPH License Fee		\$ 1,990
				Unemployment Compensation Insurance		3,968	Advertising: Employee Recruitment		2,651
				FICA Taxes		169,166	Health Care Worker Background Check		
				Employee Health Insurance		275,661	(Indicate # of checks performed 10)		351
				Employee Meals			Patient Background Checks		640
				Illinois Municipal Retirement Fund (IMRF)*		268,695	Leading Age		714
							Various Licenses/Permits		2,020
TOTAL (agree to Schedule V, line 17, col. 1)				Christmas Gifts		4,665	Various Subscriptions		33
(List each licensed administrator separately.)			\$ 67,863	Life Insurance		3,990			
B. Administrative - Other				Personal Support		1,537			
Description			Amount	Other Employee Benefits		1,133	Less: Public Relations Expense		()
N/A			\$	Less: Laundry Income Offset		(10,814)	Non-allowable advertising		()
							Yellow page advertising		()
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 778,771	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 8,399
TOTAL (agree to Schedule V, line 17, col. 3)							G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
C. Professional Services				Description		Line #	Amount		
Vendor/Payee	Type		Amount						
Templin Healthcare Accounting	Accounting		\$ 13,163				Out-of-State Travel		\$
Pointclickcare Technologies	Computer Services		32,305						
Ability Network	Computer Services		5,653						
ADP	Payroll Processing		21,152				In-State Travel		
Less: 40% of Pointclickcare Technologies reclassified to Line 10			(12,922)				Seminar Expense		410
							Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 59,351				TOTAL		\$ 410

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****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?
If YES, give association name and amount.

714 Leading Age

Yes
- (3) Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No

N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$None

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

Yes
- (8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

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

\$154,818
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No
- (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?
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.

No
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$0

Yes

Indicate the amount. \$135
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

\$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?

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?

N/A

g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

\$N/A
- (17) Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes

Schmersahl Treloar & Co., PC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.
Attach invoices and a summary of services for all architect and appraisal fees.

N/A

SEE ACCOUNTANTS' PREPARATION REPORT