

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

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: 312 West Belmont Sparta 62286

NumberCityZip Code

County: Randolph

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

HFS ID Number:

Date of Initial License for Current Owners: 1953

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT

☐ Charitable Corp.

☐ Trust

IRS Exemption Code

☐ PROPRIETARY

☒ GOVERNMENTAL

☐ Individual

☐ State

☐ Partnership

☒ County

☐ Corporation

☐ Other

☐ "Sub-S" Corp.

☐ Limited Liability Co.

☐ Trust

☐ Other

In the event there are further questions about this report, please contact:

Name: Larry TemplinTelephone Number: 630-361-2868Email 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 12/01/2024 to 11/30/2025 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)

(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(Date)

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326

(Telephone) (630) 361-2868 Fax # ()

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Randolph County Care Center

#

0000497

Report Period Beginning:

12/01/2024

Ending:

11/30/2025

III. STATISTICAL DATA

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

1

2

3

4

	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	47	Skilled (SNF)	47	17,155	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	19,345	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

1

2

3

4

5

6

7

8

9

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						1,729		1,729	8
9	SNF/PED									9
10	ICF	3,037	4,389			7,419		400	15,245	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	3,037	4,389			7,419	1,729	400	16,974	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

46.50%

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)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒ 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 certified beds.

number of certified beds 26

Medicare Intermediary CGS Administrators, LLC

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL ☒ CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 11/30/25 Fiscal Year: 11/30/25

* 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: **12/01/2024** Ending: **11/30/2025**

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	306,735	19,806	7,828	334,369		334,369		334,369			1
2	Food Purchase		173,456		173,456		173,456	(2,061)	171,395			2
3	Housekeeping	222,667	19,664		242,331		242,331		242,331			3
4	Laundry	70,259	10,578		80,837		80,837		80,837			4
5	Heat and Other Utilities			147,793	147,793		147,793		147,793			5
6	Maintenance	88,336	3,748	89,481	181,565		181,565	(2,693)	178,872			6
7	Other (specify):* Waste Disposal			5,507	5,507		5,507		5,507			7
8	TOTAL General Services	687,997	227,252	250,609	1,165,858		1,165,858	(4,754)	1,161,104			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,707,745	59,562	489,656	2,256,963		2,256,963		2,256,963			10
10a	Therapy											10a
11	Activities	103,055	344		103,399		103,399		103,399			11
12	Social Services	60,805		1,309	62,114		62,114		62,114			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,871,605	59,906	496,965	2,428,476		2,428,476		2,428,476			16
	C. General Administration											
17	Administrative	106,121			106,121		106,121		106,121			17
18	Directors Fees											18
19	Professional Services			172,001	172,001		172,001		172,001			19
20	Dues, Fees, Subscriptions & Promotions			7,098	7,098		7,098		7,098			20
21	Clerical & General Office Expenses	69,639	18,902	11,423	99,964		99,964	72,056	172,020			21
22	Employee Benefits & Payroll Taxes			1,101,002	1,101,002		1,101,002	5,527	1,106,529			22
23	Inservice Training & Education			530	530		530		530			23
24	Travel and Seminar			930	930		930		930			24
25	Other Admin. Staff Transportation			2,498	2,498		2,498		2,498			25
26	Insurance-Prop.Liab.Malpractice			113,826	113,826		113,826		113,826			26
27	Other (specify):*											27
28	TOTAL General Administration	175,760	18,902	1,409,308	1,603,970		1,603,970	77,583	1,681,553			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,735,362	306,060	2,156,882	5,198,304		5,198,304	72,829	5,271,133			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			141,161	141,161		141,161	(54,751)	86,410			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			13,141	13,141		13,141		13,141			35
36	Other (specify):*											36
37	TOTAL Ownership			154,302	154,302		154,302	(54,751)	99,551			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,109	276,431	311,540		311,540		311,540			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,940	102,940		102,940		102,940			42
43	Other (specify):* Disallowed Costs			180,132	180,132		180,132	(180,132)				43
44	TOTAL Special Cost Centers		35,109	559,503	594,612		594,612	(180,132)	414,480			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,735,362	341,169	2,870,687	5,947,218		5,947,218	(162,054)	5,785,164			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

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	(2,061)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,223)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(54,751)	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	(113,356)	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	(52,512)	43		24
25	Fund Raising, Advertising and Promotional	(7,041)	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	(2,888)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (239,832)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	77,778		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 77,778		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (162,054)		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	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Offset Miscellaneous Income Against Expense	(195)	21	4
5	Capitalize Improvement over \$2500	(2,693)	6	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	(2,888)		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
Randolph County	100	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

☐ 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	21	Administrative Wages	\$	Randolph County		\$ 72,251	\$ 72,251	1
2	V	22	Payroll Taxes		Randolph County		5,527	5,527	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			\$			\$ 77,778	\$ *	77,778 14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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	Note: No services are provided to the nursing home by Board members or their relatives										2
3	See Page Ownership-1 for a list of Board members										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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/01/2024 Ending: 1/30/2025

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 Randolph County
Street Address 1 W Taylor St
City / State / Zip Code Chester, IL 62233
Phone Number (618) 826-5000
Fax Number (618) 826-3363

	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	21	Administrative Wages	Estimated Time	195,115	21	\$ 195,115	\$ 195,115	72,251	\$ 72,251	1
2	22	Payroll Taxes	Estimated Time	14,926	21	14,926		5,527	5,527	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					\$ 210,041	\$ 195,115		\$ 77,778	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	N/A												2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$				\$		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$		15

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

X. BUILDING AND GENERAL INFORMATION:

- A.

Square Feet:

54,648

B. General Construction Type:

Exterior

Brick

Frame

Concrete & Steel

Number of Stories

1
- C.

Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

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

Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X

(c) Rent equipment from Completely Unrelated Organization.

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

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

None

- F.

List the bed capacity for the building if it differs from the licensed total.

N/A
- G.

Have you properly capitalized all major repairs and equipment purchases?

Yes
- H.

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- I.

Are you presently operating under a sublease agreement?
- J.

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

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

N/A

- K.

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	217,800		\$10,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center

0000497

Report Period Beginning:

12/01/2024

Ending:

11/30/2025

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	Display Case & Nurse Station			1987	4,278		15			4,278	15
16	Roof Repairs			1990	78,822		20			78,822	16
17	Kitchen Improvements			1990	10,593		20			10,593	17
18	Boiler & Panic Bar Doors			1991	13,143		15			13,143	18
19	Compressor & Security System			1991	5,311		10			5,311	19
20	Flooring			1993	87,160		15			87,160	20
21	Roof Replacement			1993	102,602		15			102,602	21
22	Panic Bars			1994	1,571		15			1,571	22
23	Vinyl Floor Covering & Ceiling Tile			1994	5,234		20			5,234	23
24	Carpeting			1995	1,346		5			1,346	24
25	Door with Side Light and Panic Bars			1995	3,700		15			3,700	25
26	Telephone System			1995	28,740		20			28,740	26
27	Nurse Call System			1995	6,776		10			6,776	27
28	Carpeting			1996	2,932		5			2,932	28
29	Roof Top A/C Compressors			1997	2,476		15			2,476	29
30	Replace Windows and Erect Entrance			1998	361,996		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											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

Facility Name & ID Number Randolph County Care Center

0000497

Report Period Beginning:

12/01/2024

Ending:

11/30/2025

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	Computer Wiring	2001	3,050		10		\$	\$ 3,050	37
38	35 Ton Rooftop A/C	2001	\$ 9,547	\$	15	\$		9,547	38
39	Replace Fluid Cooler	2001	4,520		15			4,520	39
40	Completed Fluid Cooler	2002	59,932		15			59,932	40
41	Boiler Repairs	2002	2,786		10			2,786	41
42	Key Access	2003	2,285		10			2,285	42
43	Vinyl Floor Ground Floor	2003	55,872		10			55,872	43
44	Resurface Kitchen & Dining Floors	2003	5,903		10			5,903	44
45	Replace Kitchen Drains	2003	18,459	1,476	25	738	(738)	15,867	45
46	Rooftop A/C	2004	6,722		15			6,722	46
47	Renovate Kitchen	2004	54,962		15			54,962	47
48	Compressor for 8.5 Ton A/C	2004	3,288		15			3,288	48
49	Hgas Line	2004	2,009		20			2,009	49
50	Handicap Shower and Wheelchair Washer	2004	13,269		20			13,269	50
51	Two Compressors for A/C	2004	6,875		15			6,875	51
52	Four Exhaust Systems	2004	4,433		15			4,433	52
53	Sewer Line Repair	2005	3,291	74	20	74		3,291	53
54	Storage Shed	2005			15				54
55	Tile Flooring	2006	2,871		15			2,871	55
56	Lanolium Flooring	2006	8,463		15			8,463	56
57	Floor Tile	2007	8,350		15			8,350	57
58	Sewage Ejector	2008	5,938	297	20	297		5,197	58
59	Sprinkler	2008	8,700	435	20	435		7,612	59
60	Sewer System Repair	2008	8,972	449	20	449		7,408	60
61	Flooring & Utility Room	2009	131,992		15			131,992	61
62	Replace Canopy	2009	21,838	1,092	20	1,092		17,897	62
63	Flooring & Utility Room	2010		75	15		(75)		63
64	Concrete Driveway Redo	2011	9,680	484	20	484		7,018	64
65	Smoke Alarm System	2011	45,824		10			45,824	65
66	Window Installed in Masonry Wall	2012	2,300	153	15	153		2,066	66
67	Rooftop Package Unit 15 Ton	2012	15,384	1,026	15	1,026		12,825	67
68	Repair Cooling Tower	2013	22,615		10			22,615	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,548,849	\$ 5,561		\$ 4,748	\$ (813)	\$ 4,533,468	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:

12/01/2024 Ending: 11/30/2025

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	
1	Totals from Page 12A, Carried Forward		\$ 4,548,849	\$ 5,561		\$ 4,748	\$ (813)	\$ 4,533,468	1
2	<u>Install Door Restrictor</u>	2014	5,963	398	15	398		4,577	2
3	<u>Install New Backflow</u>	2014	6,300	419	15	419		4,822	3
4	<u>Repair Cooling Tower</u>	2014	4,375	292	15	292		1,460	4
5	<u>Roof Repair</u>	2016	11,000	733	15	733		6,230	5
6	<u>Sealing of Smoke Partitions at Doors</u>	2017	3,588	239	15	239		2,032	6
7	<u>Wiring from Generator to Nurses Station</u>	2017	3,169	211	15	211		1,794	7
8	<u>Replaced Section of Cast Iron Pipe in Basement</u>	2017	2,904	194	15	194		1,649	8
9	<u>Walk in Cooler</u>	2018	5,793	386	15	386		2,895	9
10	<u>Replace Roof</u>	2019	296,417	11,857	25	11,857		77,070	10
11	<u>Water Heater--Boiler Room</u>	2019	7,474	498	15	498		3,237	11
12	<u>Install Heat Pump</u>	2019	3,898	260	15	260		1,690	12
13	<u>Install Console Unit for Nurses Station</u>	2019	3,776	252	15	252		1,638	13
14	<u>Air Conditioner</u>	2019	10,911	727	15	727		4,726	14
15	<u>Access Control System Installation</u>	2019	5,432	362	15	362		2,353	15
16	<u>Replaced Outside Sewer</u>	2020	14,687	979	15	979		5,384	16
17	<u>Installed New Bearing and Seal Assembly-Basement Hot Water Ci</u>	2020	2,881	192	15	192		1,056	17
18	<u>Chiller Repair</u>	2020	3,083	206	15	206		1,133	18
19	<u>Replaced Piping on Bilge Pumps</u>	2020	6,885	459	15	459		2,525	19
20	<u>Replace Cooling Tower Pump</u>	2021	5,798	387	15	387		1,741	20
21	<u>Remove and install existing starter for elevator</u>	2022	6,150	410	15	410		1,435	21
22	<u>Replaced 2 duct detectors and weather resistant housing</u>	2022	4,594	306	15	306		1,071	22
23	<u>4 Console Units-Resident Rooms</u>	2022	24,533	1,636	15	1,636		5,726	23
24	<u>Replaced water pump</u>	2022	3,356	224	15	224		784	24
25	<u>Replace Heat Exchanger-Roof Top Unit for Dining Room</u>	2023	2,887	192	15	192		480	25
26	<u>Add 4 Supports in Basement Below Tub</u>	2024	2,940	196	15	196		294	26
27	<u>Repair Leaking Check Valve</u>	2024	4,106	274	15	274		411	27
28	<u>Replace Garbage Disposal</u>	2024	2,639	176	15	176		264	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,004,388	\$ 28,026		\$ 27,213	\$ (813)	\$ 4,671,945	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,004,388	\$ 28,026		\$ 27,213	\$ (813)	\$ 4,671,945	1
2									2
3	New Parking Lot (net of grants)	2025	198,116	14,099	25	3,962	(10,137)	3,962	3
4	GEO Thermal Unit (net of grants)	2025	2,178,289	87,457	25	43,566	(43,891)	43,566	4
5	Repair Leaking Pump Station, New Piping/Flanges	2025	2,693		15	90	90	90	5
6	Replace Rooftop AC Unit	2025	7,713	257	15	257		257	6
7	Repair Pipe in Basement Tunnell	2025	7,101	237	15	237		237	7
8	Repair Sewer Line	2025	7,681	256	15	256		256	8
9	Replace15 ton Rooftop AC Unit-Dining Area	2025	23,140	771	15	771		771	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,429,121	\$ 131,103		\$ 76,352	\$ (54,751)	\$ 4,721,084	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	\$ 83,976	\$ 9,800	\$ 9,800	\$	10 Yrs	\$ 59,119	71
72	Current Year Purchases	5,162	258	258		10 Yrs	258	72
73	Fully Depreciated Assets	1,325,557					1,325,557	73
74								74
75	TOTALS	\$ 1,414,695	\$ 10,058	\$ 10,058	\$		\$ 1,384,934	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)			\$	8,900,470
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	141,161
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	86,410
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(54,751)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	6,152,672

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

G. Construction-in-Progress		
	Description	Cost
92	Building Renovations	\$ 1,264,293
93		
94		
95		\$ 1,264,293

* 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: 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: \$ 13,141 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					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name:Randolph County Care Center

IDPH License ID Number:0000497

Fiscal Year End:11/30/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Dietary Equipment	222
Telephone Equipment	3,853
Office Equipment	9,066
Total - Line 16	13,141

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
		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.
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	\$	6,051	\$ 98,884	\$	6,051	\$ 98,884	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		454	28,268		454	28,268	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2) (3)	hrs		5,719	140,643	301	5,719	140,944	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				34,808		34,808	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab					8,636			8,636	13
14	TOTAL			\$	12,224	\$ 276,431	\$ 35,109	12,224	\$ 311,540	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	\$ 81,699	\$ 81,699	1
2	Cash-Patient Deposits	1,696	1,696	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	1,186,763	1,186,763	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	654	654	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,279,212	\$ 1,279,212	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	23,147	23,147	12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	5,128,576	7,429,121	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,469,161	1,461,349	16
17	Accumulated Depreciation (book methods)	(6,213,457)	(6,152,672)	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 Construction in Progr	1,264,293	1,264,293	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,681,720	\$ 4,035,238	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,960,932	\$ 5,314,450	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 46,844	\$ 46,844	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,696	1,696	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	276,370	276,370	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,486	9,486	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	See Attached Schedule 17A	936,567	936,567	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,270,963	\$ 1,270,963	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,270,963	\$ 1,270,963	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,689,969	\$ 4,043,487	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,960,932	\$ 5,314,450	48

Facility Name:

0000497

IDPH License ID Number:

11/30/2025

Fiscal Year End:

Schedule 17A

XV. Balance Sheet

Line 37 Other

	Operating	After Consolidation
Accrued IMRF	7,248	7,248
Deferred Pension Liability	918,456	918,456
Employee Benefit Fund	10,863	10,863
TOTAL	936,567	936,567

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,601,957	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,601,956	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,251,187)	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	2,339,200	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,088,013	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)	\$ 6,689,969	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Randolph County Care Center

0000497

Report Period Beginning: 12/01/2024

Ending: 11/30/2025

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,472,106	1
2	Discounts and Allowances for all Levels	1,002,702	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,474,808	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	189,260	6
7	Oxygen	875	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 190,135	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	2,061	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	9,146	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,207	23
	D. Non-Operating Revenue		
24	Contributions	2,642	24
25	Interest and Other Investment Income***	2,633	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,275	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	195	28
28a	Inter-Governmental Transfer	14,411	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,606	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,696,031	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,165,858	31
32	Health Care	2,428,476	32
33	General Administration	1,603,970	33
	B. Capital Expense		
34	Ownership	154,302	34
	C. Ancillary Expense		
35	Special Cost Centers	491,672	35
36	Provider Participation Fee	102,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,947,218	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,251,187)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,251,187)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 646,785.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,194,254.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,587,104.00	48
49	Medicare Part A	968,245.00	49
50	Other-(specify) Hospice	78,420.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,474,808	56

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	405	626	\$ 22,572	\$ 36.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,929	3,177	142,333	44.80	3
4	Licensed Practical Nurses	13,377	14,020	444,221	31.68	4
5	CNAs & Orderlies	42,352	45,580	1,042,619	22.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,914	4,541	103,055	22.69	10
11	Social Service Workers	2,175	2,379	60,805	25.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,877	17,243	306,735	17.79	15
16	Dishwashers					16
17	Maintenance Workers	3,772	4,099	88,336	21.55	17
18	Housekeepers	11,854	13,042	222,667	17.07	18
19	Laundry	3,887	4,175	70,259	16.83	19
20	Administrator	1,980	2,389	106,121	44.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,106	2,142	69,639	32.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,042	2,194	56,000	25.52	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,670	115,607	\$ 2,735,362 *	\$ 23.66	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	Monthly	\$ 4,120	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	1,686	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)		\$ 11,806		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6	\$ 458	L10, C3	50
51	Licensed Practical Nurses	5,178	300,784	L10, C3	51
52	Certified Nurse Assistants/Aides	5,199	172,589	L10, C3	52
53	TOTAL (lines 50 - 52)	10,383	\$ 473,831		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number		Randolph County Care Center		STATE OF ILLINOIS		# 0000497		Report Period Beginning:		12/01/2024		Ending:		11/30/2025	
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions					
Name		Function		%		Amount		Description		Amount		Description		Amount	
Michelle Cato		Administrator		0		\$ 62,699		Workers' Compensation Insurance		\$ 64,836		IDPH License Fee		\$ 1,900	
Tammy von Yeast		Administrator		0		43,422		Unemployment Compensation Insurance		5,445		Advertising: Employee Recruitment		466	
								FICA Taxes		212,477		Health Care Worker Background Check			
								Employee Health Insurance		186,167		(Indicate # of checks performed 7)		321	
								Employee Meals				Patient Background Checks		39 746	
								Illinois Municipal Retirement Fund (IMRF)*		631,716		Association Dues (total from pg 22, #4)			
								Personal Support		1,044		Various Licenses/Permits		3,665	
								Life Insurance		4,043					
								Other Employee Benefits		801					

* 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)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
N/A	
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

N/A	
	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

N/A	
	Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 6,212 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 102,940

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

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?

Yes Indicate the amount. \$ 2,061
- (12)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100% Line 14

d. Have vehicle usage logs been maintained?

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. \$ N/A

No
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: Schmersahl Treloar & Co. Yes
- (14)

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

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details. N/A

Attach invoices and a summary of services for all architect and appraisal fees.