

Facility Name & ID Number Randolph County Care Center

0000497 Report Period Beginning: 12/1/17 Ending: 11/30/18

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 N/A

	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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,464	653	2,268	4,385	8
9	SNF/PED					9
10	ICF	9,515	9,762		19,277	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,979	10,415	2,268	23,662	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.83%

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 2,068

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: 11/30/18 Fiscal Year: 11/30/18

* 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: 12/1/17 Ending: 11/30/18

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	215,858	11,395	8,333	235,586		235,586		235,586		1
2	Food Purchase		152,191		152,191		152,191	(312)	151,879		2
3	Housekeeping	168,309	19,601		187,910		187,910		187,910		3
4	Laundry	160,912	10,954		171,866		171,866	(51,608)	120,258		4
5	Heat and Other Utilities			151,176	151,176		151,176		151,176		5
6	Maintenance	67,764	14,959	90,564	173,287		173,287		173,287		6
7	Other (specify):* Waste Disposal			6,710	6,710		6,710		6,710		7
8	TOTAL General Services	612,843	209,100	256,783	1,078,726		1,078,726	(51,920)	1,026,806		8
	B. Health Care and Programs										
9	Medical Director			6,005	6,005		6,005		6,005		9
10	Nursing and Medical Records	1,350,761	34,544	21,503	1,406,808		1,406,808		1,406,808		10
10a	Therapy										10a
11	Activities	63,591	55		63,646		63,646	(55)	63,591		11
12	Social Services	49,218			49,218		49,218		49,218		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,463,570	34,599	27,508	1,525,677		1,525,677	(55)	1,525,622		16
	C. General Administration										
17	Administrative	91,170			91,170		91,170		91,170		17
18	Directors Fees										18
19	Professional Services			50,984	50,984		50,984		50,984		19
20	Dues, Fees, Subscriptions & Promotions			13,049	13,049		13,049		13,049		20
21	Clerical & General Office Expenses	78,778	11,730	25,561	116,069		116,069	(364)	115,705		21
22	Employee Benefits & Payroll Taxes			2,501,622	2,501,622		2,501,622	(12,106)	2,489,516		22
23	Inservice Training & Education			21	21		21		21		23
24	Travel and Seminar			1,357	1,357		1,357		1,357		24
25	Other Admin. Staff Transportation			1,998	1,998		1,998		1,998		25
26	Insurance-Prop.Liab.Malpractice			75,635	75,635		75,635		75,635		26
27	Other (specify):*										27
28	TOTAL General Administration	169,948	11,730	2,670,227	2,851,905		2,851,905	(12,470)	2,839,435		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,246,361	255,429	2,954,518	5,456,308		5,456,308	(64,445)	5,391,863		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			68,318	68,318		68,318		68,318		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			4,265	4,265		4,265		4,265		35
36	Other (specify):*										36
37	TOTAL Ownership			72,583	72,583		72,583		72,583		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		56,041	513,571	569,612		569,612		569,612		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			188,530	188,530		188,530		188,530		42
43	Other (specify):* See Att Sch 4A			534,069	534,069		534,069	(529,115)	4,954		43
44	TOTAL Special Cost Centers		56,041	1,236,170	1,292,211		1,292,211	(529,115)	763,096		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,246,361	311,470	4,263,271	6,821,102		6,821,102	(593,560)	6,227,542		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 12/1/17
 Period End 11/30/18

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					5	6	7
	Ancillary Expense											
	E. Special Cost Centers											
43	Other (specify):*				0		0		0			
	Laboratory/Expenses			4,954	4,954		4,954		4,954			
	Radiology Expenses				0		0		0			
	Non-Allowable Expenses			529,115	529,115		529,115	(529,115)	0			
					0		0		0			
					0		0		0			
	TOTAL Other Special C	0	0	534,069	534,069	0	534,069	(529,115)	4,954			

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(312)	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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(523,738)	43		24
25	Fund Raising, Advertising and Promotional	(5,377)	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	(64,133)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (593,560)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (593,560)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' PREPARATION REPORT

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ID# 0000497

Report Period Beginning: 12/1/17

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income Against Expense	\$ (364)	21	1
2	Offset Miscellaneous Income Against Expense	(55)	11	2
3	Offset Laundry Income Against Wages	(48,422)	4	3
4	Offset Laundry Income Against Employee Ben.	(12,106)	22	4
5	Offset Laundry Income Against Laundry Supplies	(3,186)	4	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
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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	(64,133)		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						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Randolph County Care Center

0000497

Report Period Beginning:

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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:		None		None			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
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center # 0000497 Report Period Beginning: 12/1/17 Ending: 11/30/18

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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' PREPARATION REPORT

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Randolph County Care Center

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Ending:

11/30/18

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. \$ _____ Line # _____

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

(See instructions.)

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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2017	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2013	8	
	2014	9	
	2015	10	
	2016	11	
	2017	12	
N/A - County facility does not pay real estate taxes			
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Randolph County Care Center COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0000497

CONTACT PERSON REGARDING THIS REPORT Larry Templin

TELEPHONE (630) 361-2868 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Randolph County Care Center

0000497

Report Period Beginning:

12/1/17

Ending:

11/30/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] NO

If so, please complete the following:

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Nursing Home, 217,800, 1950, \$ 10,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 217,800, (blank), \$ 10,000, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center

0000497

Report Period Beginning:

12/1/17

Ending:

11/30/18

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	9,046	20	9,046		361,996	30
31	Air Cond System		1999		179,160		15			179,160	31
32	Mini-Kitchen Sink		1999		960	48	20	48		936	32
33	TV Antenna System		1999		1,792	90	20	90		1,755	33
34	Door Monitor System		1999		8,358		5			8,358	34
35	Generator Fuel Tank		1999		9,875	494	20	494		9,632	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:

12/1/17

Ending:

11/30/18**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		10,701	44
45	Rooftop A/C	2004	6,722	448	15	448		6,496	45
46	Renovate Kitchen	2004	54,962	3,664	15	3,664		53,128	46
47	Compressor for 8.5 Ton A/C	2004	3,288	219	15	219		3,176	47
48	Hgas Line	2004	2,009	100	20	100		1,450	48
49	Handicap Shower and Wheelchair Washer	2004	13,269	663	20	663		9,614	49
50	Two Compressors for A/C	2004	6,875	458	15	458		6,641	50
51	Four Exhaust Systems	2004	4,433	296	15	296		4,292	51
52	Sewer Line Repair	2005	3,291	165	20	165		2,227	52
53	Storage Shed	2005	1,150	77	15	77		1,039	53
54	Tile Flooring	2006	2,871	191	15	191		2,388	54
55	Lanolium Flooring	2006	8,463	564	15	564		7,050	55
56	Floor Tile	2007	8,350	557	15	557		6,405	56
57	Sewage Ejector	2008	5,938	297	20	297		3,118	57
58	Sprinkler	2008	8,700	435	20	435		4,567	58
59	Sewer System Repair	2008	8,972	449	20	449		4,265	59
60	Flooring & Utility Room	2009	131,992	8,799	15	8,799		83,597	60
61	Replace Canopy	2009	21,838	1,092	20	1,092		10,253	61
62	Flooring & Utility Room	2010	2,337	156	15	156		1,326	62
63	Concrete Driveway Redo	2011	9,680	484	20	484		3,630	63
64	Smoke Alarm System	2011	50,923	5,092	10	5,092		33,098	64
65	Window Installed in Masonry Wall	2012	2,300	153	15	153		995	65
66	Rooftop Package Unit 15 Ton	2013	15,384	1,026	15	1,026		5,643	66
67	Repair Cooling Tower	2013	22,615	2,262	10	2,262		12,441	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,557,435	\$ 38,063		\$ 38,063	\$	\$ 4,419,850	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:

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Ending:

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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	\$ 4,557,435	\$ 38,063		\$ 38,063	\$	\$ 4,419,850		1
2									2
3	Install Door Restrictor	2014 5,963	398	15	398		1,791		3
4	Install New Backflow	2014 6,300	419	15	419		1,889		4
5	Repair Cooling Tower	2014 4,375	292	15	292		1,314		5
6	Roof Repair	2016 11,000	733	15	733		1,099		6
7	Sealing of Smoke Partitions at Doors	2017 3,588	239	15	239		359		7
8	Wiring from Generator to Nurses Station	2017 3,169	211	15	211		317		8
9	Replaced Section of Cast Iron Pipe in Basement	2017 2,904	194	15	194		291		9
10	Walk in Cooler	2018 5,793	193	15	193		193		10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,600,527	\$ 40,742		\$ 40,742	\$	\$ 4,427,103		34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Randolph County Care Center

0000497

Report Period Beginning:

12/1/17

Ending:

11/30/18

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	\$ 293,920	\$ 27,213	\$ 27,213	\$	3-15 Years	\$ 180,101	71
72	Current Year Purchases	7,253	363	363		10 Years	363	72
73	Fully Depreciated Assets	1,064,512					1,064,512	73
74								74
75	TOTALS	\$ 1,365,685	\$ 27,576	\$ 27,576	\$		\$ 1,244,976	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport Residents	2002 Chevy Bus	2002	\$ 46,654	\$	\$	\$	5	\$ 46,654	76
77										77
78										78
79										79
80	TOTALS			\$ 46,654	\$	\$	\$		\$ 46,654	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,022,866	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 68,318	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,318	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,718,733	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center

0000497

Report Period Beginning: 12/1/17

Ending: 11/30/18

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 4,265 Description: Dish Machine \$1,049, Medical Equipment \$3,215

(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	<u>N/A</u>				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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		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)	\$			

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.)

	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	\$	3,441	\$ 247,774	\$	3,441	\$ 247,774	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,123	227,195		2,123	227,195	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2), (3)	hrs		748	37,376		748	37,376	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				56,041		56,041	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Ambulance</u>					1,226			1,226	13
14	TOTAL			\$	6,312	\$ 513,571	\$ 56,041	6,312	\$ 569,612	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **11/30/18**

(last day of reporting year)

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	\$ 176,254	\$ 176,254	1
2	Cash-Patient Deposits	3,130	3,130	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>521,104</u>)	790,221	790,221	3
4	Supply Inventory (priced at <u>Cost</u>)	8,400	8,400	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	17,439	17,439	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 995,444	\$ 995,444	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	445,934	445,934	12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	4,600,527	4,600,527	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,412,339	1,412,339	16
17	Accumulated Depreciation (book methods)	(5,719,286)	(5,718,733)	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)	\$ 749,514	\$ 750,067	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,744,958	\$ 1,745,511	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 210,451	\$ 210,451	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,130	3,130	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	192,351	192,351	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,462	25,462	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>	2,700,572	2,700,572	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,131,966	\$ 3,131,966	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)	\$ 3,131,966	\$ 3,131,966	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,387,008)	\$ (1,386,455)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,744,958	\$ 1,745,511	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Randolph County Care Center

Period 12/1/17

Period 11/30/18

Schedule 17A

XV. Balance Sheet

Line 23 Other

	Operating	After Consolidation
Accrued IMRF	3,222	3,222
Deferred Pension Liability	2,690,191	2,690,191
Due to Public Aid	29	29
Employee Benefit Fund	7,130	7,130
TOTAL	<u>2,700,572</u>	<u>2,700,572</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (227,841)	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)	\$ (227,840)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,065,240)	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	906,072	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,159,168)	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)	\$ (1,387,008)	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: **12/1/17**

Ending: **11/30/18**

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	\$ 3,384,594	1
2	Discounts and Allowances for all Levels	666,423	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,051,017	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	451,747	6
7	Oxygen	575	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 452,322	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	312	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,040	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	9,548	21
22	Laundry	63,714	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 74,614	23
D. Non-Operating Revenue			
24	Contributions	10,008	24
25	Interest and Other Investment Income***	5,880	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,888	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	964	28
28a	Inter-Governmental Transfer	161,057	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 162,021	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,755,862	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,078,726	31
32	Health Care	1,525,677	32
33	General Administration	2,851,905	33
B. Capital Expense			
34	Ownership	72,583	34
C. Ancillary Expense			
35	Special Cost Centers	1,103,681	35
36	Provider Participation Fee	188,530	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,821,102	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,065,240)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,065,240)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,423,225	44
45	Private Pay - Net Inpatient Revenue	1,576,341	45
46	Medicare - Net Inpatient Revenue	941,379	46
47	Other-(specify) Managed Care	110,072	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,051,017	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center

0000497

Report Period Beginning:

12/1/17

Ending:

11/30/18

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,352	\$ 70,031	\$ 29.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,074	3,621	81,459	22.50	3
4	Licensed Practical Nurses	13,933	15,519	300,076	19.34	4
5	CNAs & Orderlies	53,910	60,913	868,282	14.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,284	4,708	63,591	13.51	10
11	Social Service Workers	2,695	3,576	49,218	13.76	11
12	Dietician					12
13	Food Service Supervisor	1,007	1,413	18,245	12.91	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,308	16,041	197,613	12.32	15
16	Dishwashers					16
17	Maintenance Workers	3,999	4,174	67,764	16.23	17
18	Housekeepers	10,226	12,055	168,309	13.96	18
19	Laundry	10,188	11,610	160,912	13.86	19
20	Administrator	2,080	2,872	91,170	31.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,074	4,538	78,778	17.36	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	1,850	2,063	30,913	14.98	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,708	145,455	\$ 2,246,361 *	\$ 15.44	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	\$ 8,333	L1, C3	35
36	Medical Director	Monthly	6,005	L9, C3	36
37	Medical Records Consultant	4 Visits	1,007	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,214	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)		\$ 17,559		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	147	\$ 5,112	L10, C3	50
51	Licensed Practical Nurses	196	5,781	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	343	\$ 10,893		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Randolph County Care Center# 0000497

Report Period Beginning:

12/1/17

Ending:

11/30/18**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 4,067 Leading Age
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 188,530
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 312
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% line 14
d. Have vehicle usage logs been maintained? Adequate records have been maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Schmersahl Treloar & Co., PC
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT