

STATE OF ILLINOIS

Facility Name & ID Number Randolph House

0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,464</u>			<u>5,464</u>	13
14	TOTALS	<u>5,464</u>			<u>5,464</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.56%

D. How many bed-hold days during this year were paid by Public Aid?

249 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

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

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 12/15/86

J. Was the facility purchased or leased after January 1, 1978?

YES Date 12/15/86 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/02 Fiscal Year: 12/31/02

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

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	31,864	2,387	1,198	35,449		35,449	35,449			1
2	Food Purchase		37,245		37,245	(932)	36,313	36,313			2
3	Housekeeping	14,463	5,977		20,440		20,440	20,440			3
4	Laundry	2,091	874		2,965		2,965	2,965			4
5	Heat and Other Utilities			10,299	10,299		10,299	10,299			5
6	Maintenance	8,149	4,610	3,007	15,766		15,766	15,766			6
7	Other (specify):*										7
8	TOTAL General Services	56,567	51,093	14,504	122,164	(932)	121,232	121,232			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	98,468	1,977	9,760	110,205	(18)	110,187	110,187			10
10a	Therapy										10a
11	Activities	22,171	294	227	22,692		22,692	22,692			11
12	Social Services	1,304			1,304		1,304	1,304			12
13	Nurse Aide Training										13
14	Program Transportation		830	1,656	2,486	(2,006)	480	480			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	121,943	3,101	11,643	136,687	(2,024)	134,663	134,663			16
	C. General Administration										
17	Administrative	22,752		41,600	64,352	(105)	64,247	64,247			17
18	Directors Fees										18
19	Professional Services			792	792		792	792			19
20	Dues, Fees, Subscriptions & Promotions			334	334		334	334			20
21	Clerical & General Office Expenses	13,970	2,392	2,679	19,041		19,041	19,041			21
22	Employee Benefits & Payroll Taxes			69,108	69,108	932	70,040	70,040			22
23	Inservice Training & Education					123	123	123			23
24	Travel and Seminar			42	42		42	42			24
25	Other Admin. Staff Transportation			892	892		892	892			25
26	Insurance-Prop.Liab.Malpractice			5,143	5,143		5,143	5,143			26
27	Other (specify):*										27
28	TOTAL General Administration	36,722	2,392	120,590	159,704	950	160,654	160,654			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	215,232	56,586	146,737	418,555	(2,006)	416,549	416,549			29

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

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

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Facility Name & ID Number Randolph House #0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			5,234	5,234		5,234		5,234			33
34	Rent-Facility & Grounds			54,180	54,180		54,180		54,180			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			59,414	59,414		59,414		59,414			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					2,006	2,006		2,006			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,149	34,149		34,149		34,149			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			34,149	34,149	2,006	36,155		36,155			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	215,232	56,586	240,300	512,118		512,118		512,118			45

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

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ None		\$	30

OHF USE ONLY						
48		49		50		51
						52

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

		1	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)	\$ None		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ None		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		\$ 2,006	L14	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	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$ 2,006		47

STATE OF ILLINOIS

Randolph House

ID# 0031633

Report Period Beginning: 01/01/02

Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rita Armbrust	100%	Reservoir Manor	Shelbyville			

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.

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	Rita Armbrust	Owner	Accounting	1.00	*\$15,600	24	60.00	Contractual	\$ 26,000	L17 C3	1
2	Dennis Armbrust	Manager	Administrative	0.00	**\$26,000	16	40.00	Contractual	15,600	L17 C3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10					*Reservoir Manor	\$15,600					10
11					**Reservoir Manor	\$26,000					11
12											12
13								TOTAL	\$ 41,600		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

STATE OF ILLINOIS

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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

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

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

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	L34 C3	Rent Expense	Licensed Days	32	2	\$ 1,440	\$ 0	16	\$ 720	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					\$ 1,440	\$		\$ 720	25

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$ None	15										

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2001 report.		\$ 4,523	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.)		\$ 4,879	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 356	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 4,878	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.)		\$ N/A	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.)		\$ N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 5,234	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	3,986	8
	1998	4,056	9
	1999	4,227	10
	2000	4,522	11
	2001	4,879	12
The R.E. Tax bill for 2001 was \$4878.36. We based 2002's accrued R.E. Tax estimate of \$4878 on 2001's taxes.			
		FOR OHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2001 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Randolph House COUNTY Fayette

FACILITY IDPH LICENSE NUMBER 0031633

CONTACT PERSON REGARDING THIS REPORT Rita Armbrust

TELEPHONE 618 548-0309 FAX #: 618 548-3720

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 182-14-00-500-508	All Blk 62	\$ 4,878.36	\$ 4,878.36
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>4,878.36</u>	\$ <u>4,878.36</u>

B. Real Estate Tax Cost Allocation:

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

STATE OF ILLINOIS

Facility Name & ID Number Randolph House

0031633

Report Period Beginning:

01/01/02

Ending:

12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,500 B. General Construction Type: Exterior Vinyl Siding Frame Wood; sprinklered Number of Stories 1.5

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide 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 NO
If so, please complete the following:

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>N/A</u>	<u>N/A</u>		\$	1
2					2
3	TOTALS	<u>N/A</u>		\$ <u>N/A</u>	3

STATE OF ILLINOIS

Facility Name & ID Number **Randolph House**

0031633

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Asphalt Parking Lot		1987	2,420		10			2,420	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

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

See Page 12A, Line 70 for total

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

STATE OF ILLINOIS

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0031633

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,420	\$		\$	\$	\$ 2,420	70

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

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 6,839	\$	\$	\$	10	\$ 6,839	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 6,839	\$	\$	\$		\$ 6,839	75

D. Vehicle Depreciation (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	Activities, Shopping	1994 Dodge Van	1994	\$ 20,914	\$	\$	\$	4	\$ 20,914	76
77										77
78										78
79										79
80	TOTALS			\$ 20,914	\$	\$	\$		\$ 20,914	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)	\$ 30,173	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ None	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ None	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ None	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 30,173	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ None	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$ None	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.

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Nick Striglos (Mgmt. Office lease is held by Jack Woods)

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1986	16	12/15/86	\$ 53,460	15	5	3
4	Additions							4
5	Office Rent			03/09/97	720	5	0	5
6								6
7	TOTAL		16		\$ 54,180			7

10. Effective dates of current rental agreement:
Beginning 12/04/86
Ending 12/04/06

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

	Fiscal Year Ending	Annual Rent
12.	<u>12/31/2003</u>	\$ <u>53,460</u>
13.	<u>12/31/2004</u>	\$ <u>53,460</u>
14.	<u>12/31/2005</u>	\$ <u>53,460</u>

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
0
0

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ N/A Description: Not Determinable from Lease Agreement
(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			\$ 0.00	\$	17
18					18
19					19
20					20
21	TOTAL		\$ None	\$	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.

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

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

<p>1. HAVE YOU TRAINED AIDES 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. CLASSROOM PORTION:</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 AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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	Nurse Aide 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 aides from other facilities.

\$ _____

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
1	Licensed Occupational Therapist		hrs	\$		\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs									4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescripts									9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify):											13
14	TOTAL			\$ 0	0	\$ 0	0	\$ 0	0	\$ 0	0	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 nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 45,408	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	117,192		3
4	Supply Inventory (priced at cost)	2,302		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,619		6
7	Other Prepaid Expenses	200		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 167,721	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,420		15
16	Equipment, at Historical Cost	27,753		16
17	Accumulated Depreciation (book methods)	(30,173)		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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 167,721	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,548	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,012		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,027		31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,878		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>DT Payable (In-Transit)</u>	9,997		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 27,462	\$	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)	\$ 27,462	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 140,259	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 167,721	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 148,685	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 148,685	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	41,574	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	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (8,426)	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)	\$ 140,259	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 550,613	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 550,613	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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	2,006	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,006	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,073	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,073	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 553,692	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	122,164	31
32	Health Care	136,687	32
33	General Administration	159,704	33
B. Capital Expense			
34	Ownership	59,414	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	34,149	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 512,118	40
41	Income before Income Taxes (line 30 minus line 40)**	41,574	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 41,574	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? See Pg. 19A 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.

STATE OF ILLINOIS

Facility Name & ID Number Randolph House

0031633

Report Period Beginning:

01/01/02

Ending:

12/31/02

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			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,301	1,365	12,971	9.50	9
10	Activity Assistants	1,122	1,122	9,200	8.20	10
11	Social Service Workers	100	104	1,304	12.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,564	1,636	15,825	9.67	14
15	Cook Helpers/Assistants	1,864	1,906	16,039	8.42	15
16	Dishwashers					16
17	Maintenance Workers	966	976	8,149	8.35	17
18	Housekeepers	1,431	1,585	14,463	9.12	18
19	Laundry	261	261	2,091	8.01	19
20	Administrator	200	208	2,607	12.53	20
21	Assistant Administrator	903	939	20,145	21.45	21
22	Other Administrative					22
23	Office Manager	502	522	7,646	14.65	23
24	Clerical	683	685	6,324	9.23	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)	11,258	11,770	98,468	8.37	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,155	23,079	\$ 215,232 *	\$ 9.33	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	25	\$ 1,198	L1 C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	157	4,191	L10 C3	38
39	Pharmacist Consultant	24	1,200	L10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	394	L10 C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	24	2,400	L10 C3	47
48	Psychologist Consultant	17	1,575	L10 C3	48
49	TOTAL (lines 35 - 48)	254	\$ 10,958		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	None	\$ None		53

STATE OF ILLINOIS

Facility Name & ID Number **Randolph House**

0031633

Report Period Beginning: **01/01/02**

Ending: **12/31/02**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Trena Briscoe	L.N.H.A.	0.00%	\$ 2,607	Workers' Compensation Insurance	\$ 3,911	IDPH License Fee	\$ 200		
Carolyn Mays	Asst. Admn.	0.00%	20,145	Unemployment Compensation Insurance	1,642	Advertising: Employee Recruitment			
				FICA Taxes	15,864	Health Care Worker Background Check	24		
				Employee Health Insurance	22,095	(Indicate # of checks performed <u>2</u>)			
				Employee Meals	932	Vehicle License	78		
				Illinois Municipal Retirement Fund (IMRF)*		Subscription	32		
				SEP/IRA Fund for Employees (See Pg. 21A)	25,546				
				PPD Testing for Staff	50				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 22,752	TOTAL (agree to Schedule V, line 22, col.8)		\$ 70,040			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount	
Rita Armbrust			\$ 26,000				Out-of-State Travel	\$	
Dennis Armbrust			15,600						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 41,600				In-State Travel		
C. Professional Services							Seminar in Flora	42	
Vendor/Payee	Type		Amount				Seminar Expense		
Krehbiel & Associates	Cost Report Adjustments		\$ 750						
Vandalia Leader-Union	Non-discriminatory Notice		42				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 792	TOTAL		\$ 0	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 42

* Attach copy of IMRF notifications

**See instructions.

STATE OF ILLINOIS

Facility Name & ID Number Randolph House

0031633

Report Period Beginning: 01/01/02

Ending: 12/31/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? No new purchase
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 399 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? _____
If YES, give effective date of lease. No
- (9) Are you presently operating under a sublease agreement? _____ YES No NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 34,149
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? Yes 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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 932 Has any meal income been offset against related costs? N/A No Meal I Indicate the amount. \$ None
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 2,006
c. What percent of all travel expense relates to transportation of nurses and patients? 72.69%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Line 25 Other Administrative Staff Transportation

Mileage reimbursed to Trena Briscoe, L.N.H.A., Q.M.R.P., from her management office in Flora to Randolph House was \$812. Ms. Briscoe is the administrator of three 16-bed ICF-DD's and is a consultant for other facilities. She is scheduled to come to Randolph House one day each week. Mileage logs have been maintained by Ms. Briscoe and she bills the facility monthly for her travel.

Mileage reimbursed to Charlotte Watton, M.S.W., from her management office in Shelbyville to Randolph House was \$80. Mrs. Watton does consulting work at several other facilities. Mileage logs have been maintained by Mrs. Watton and she bills the facility monthly for her travel.

Briscoe	\$812
Watton	<u>\$80</u>
Total L25	\$892

A

Line 22	Employee Benefits	\$ 932.00	
Line 2	Food	\$ 932.00	

To re-classify employee meals to employee benefits.

B

Line 38	Medically Necessary Transportat	\$ 2,006.00	
Line 14	Program Transportation	\$ 2,006.00	

To re-classify so that Line 28 will equal \$2006, the amount accrued for medically necessary transportation.

C

Line 23	Inservice Training and Education	\$123	
Line 10	Nursing and Medical Records	\$18	
Line 17	Administrative	\$105	

To re-classify for in-services as follows:

Charlotte Watton, M.S.W., on 11/19/02

Trena Briscoe, LNHA, on 3/13/02, 3/13/02, 11/19/02, 11/19/02, and 11/19/02

Reconciliation of Cost Report and Tax Return

Income Tax Return	Gross Revenue (includes DT)	\$ 658,306.00
	Total Expenses (includes DT)	<u>\$ (596,454.00)</u>
Income Tax Return Net Income (Cash Basis)		\$ 61,852.00
Plus:		
12/31/02 A/R	\$ 117,192.00	
12/31/02 DT A/R	\$ 34,348.00	
12/31/01 Payables	\$ 28,625.00	
12/31/01 DT Payable	\$ 24,609.00	
12/31/02 DT In-Transit Payable	\$ 9,997.00	
12/31/02 Prepaid Insurance	\$ 2,619.00	
12/31/02 Prepaid License Fee	<u>\$ 200.00</u>	
Total Additions		\$ 217,590.00
Less:		
12/31/01 DT A/R	\$ 24,609.00	
12/31/01 A/R	\$ 93,183.00	
12/31/02 Payables	\$ 27,462.00	
12/31/02 DT Payable	\$ 34,348.00	
12/31/01 DT In-Transit Payable	\$ 12,304.00	
12/31/01 Prepaid Insurance	\$ 2,055.00	
Owners' Contractual Pay	\$ 41,600.00	
12/31/01 Prepaid Employee Insurance	\$ 1,891.00	
12/31/01 DT AJE	\$ 76.00	
12/31/01 Adj. for A/R	\$ 11.00	
12/31/02 Adj. for A/R	\$ 317.00	
12/31/01 Prepaid Expense	<u>\$ 12.00</u>	
Total Deductions		<u>\$ (237,868.00)</u>
Cost Report Net Income (Accrual Basis)		\$ 41,574.00