



Facility Name & ID Number Randolph House

# 0031633 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	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					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,437			5,437	13
14	TOTALS	5,437			5,437	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.10%

D. How many bed-hold days during this year were paid by the Department? 200 (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: 12/31/05 Fiscal Year: 12/31/05

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

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjustments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	32,754	2,569	1,202	36,525		36,525		36,525		1
2	Food Purchase		37,359		37,359	(932)	36,427		36,427		2
3	Housekeeping	12,629	5,240		17,869		17,869		17,869		3
4	Laundry	2,661	795		3,456		3,456		3,456		4
5	Heat and Other Utilities			12,212	12,212		12,212		12,212		5
6	Maintenance	5,156	1,694	3,744	10,594		10,594	5,362	15,956		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	53,200	47,657	17,158	118,015	(932)	117,083	5,362	122,445		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	101,737	2,742	15,184	119,663	(286)	119,377		119,377		10
10a	Therapy										10a
11	Activities	17,717	133	502	18,352		18,352		18,352		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation		2,254	1,648	3,902	(2,398)	1,504		1,504		14
15	Other (specify):* <b>H.A. Training</b>	1,001	25		1,026	200	1,226		1,226		15
16	<b>TOTAL Health Care and Programs</b>	120,455	5,154	17,334	142,943	(2,484)	140,459		140,459		16
	<b>C. General Administration</b>										
17	Administrative	21,596		41,600	63,196	(170)	63,026		63,026		17
18	Directors Fees										18
19	Professional Services			1,425	1,425		1,425		1,425		19
20	Dues, Fees, Subscriptions & Promotions			198	198		198	(35)	163		20
21	Clerical & General Office Expenses	14,344	2,589	2,443	19,376		19,376		19,376		21
22	Employee Benefits & Payroll Taxes			89,189	89,189	932	90,121		90,121		22
23	Inservice Training & Education					256	256		256		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			10,552	10,552	1,543	12,095		12,095		25
26	Insurance-Prop.Liab.Malpractice			5,597	5,597		5,597		5,597		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	35,940	2,589	151,004	189,533	2,561	192,094	(35)	192,059		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	209,595	55,400	185,496	450,491	(855)	449,636	5,327	454,963		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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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			6,506	6,506		6,506		6,506			33
34	Rent-Facility & Grounds			54,180	54,180		54,180		54,180			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			60,686	60,686		60,686		60,686			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					855	855		855			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,222	36,222		36,222		36,222			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			36,222	36,222	855	37,077		37,077			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	209,595	55,400	282,404	547,399		547,399	5,327	552,726			45

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

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**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
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	<b>35</b>	<b>L20</b>		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ 35</b>		<b>\$</b>	<b>30</b>

<b>OHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ 35</b>		<b>37</b>

\*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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.	x		\$ 1,276	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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$ 1,276</b>		<b>47</b>

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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	<b>Total</b>	0	49





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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.

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## 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	*\$26,000	24	60.00	Contractual	\$ 41,600	L17 C3	1
2											2
3											3
4											4
5											5
6											6
7											7
8					*Reservoir Manor \$26,000						8
9											9
10											10
11											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

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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     Health Care Mgmt. Corp.      
 Street Address     122 N. Hote Rd.      
 City / State / Zip Code     Salem, IL 62881      
 Phone Number     (618) 548-0309      
 Fax Number     (618) 548-3720    

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	32	2	1,440	\$ 0	\$ 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					\$	\$		\$ 720	25

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**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		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$				\$								
2																		
3																		
4																		
5																		
<b>Working Capital</b>																		
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>					\$	\$			\$								
<b>B. Non-Facility Related*</b>																		
10																		
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$								
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ None								

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

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

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

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

**B. Real Estate Taxes**

<p><b>Important</b>, 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 2004 report.		\$	<b>5,443</b>
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.)		\$	<b>5,975</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>532</b>
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>5,974</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>6,506</b>
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	<b>4,522</b>	<b>8</b>
	2001	<b>4,879</b>	<b>9</b>
	2002	<b>5,162</b>	<b>10</b>
	2003	<b>5,443</b>	<b>11</b>
	2004	<b>5,975</b>	<b>12</b>
<b>The R.E. tax bill for 2004 was \$5,974.72.</b>			
<b>We based 2005's accrued R.E. tax estimate of \$5974 on 2004's taxes.</b>			
	<b>FOR OHF USE ONLY</b>		
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2004 \$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>

**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.**



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**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 5,500 B. General Construction Type: Exterior Vinyl Siding Frame Wood; sprinklered Number of Stories 1 1/2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

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**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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.

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

See Page 12A, Line 70 for total

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**XI. OWNERSHIP COSTS (continued)**

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

1	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		\$	\$		\$	\$	\$	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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$ <b>2,420</b>		\$	\$	\$ <b>2,420</b>	70

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

Facility Name & ID Number Randolph House

# 0031633

Report Period Beginning:

01/01/05

Ending:

12/31/05

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.

**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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1986</u>	<u>16</u>	<u>12/15/86</u>	\$ <u>53,460</u>	<u>15</u>	<u>5</u>	3
4	Additions							4
5	Office Rent			<u>03/09/02</u>	<u>720</u>	<u>5</u>	<u>0</u>	5
6								6
7	TOTAL		<u>16</u>		\$ <u>54,180</u>			7

8. List separately any amortization of lease expense included on page 4, line 34. 0  
 This amount was calculated by dividing the total amount to be amortized 0  
 by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ <u>None</u>	\$ _____	21

10. Effective dates of current rental agreement:

Beginning 12/15/86

Ending 12/15/06

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

Fiscal Year Ending Annual Rent

12. 12/31/2006 \$ 51,805

13. 12/31/2007 \$ Not Determinable

14. 12/31/2008 \$ Not Determinable

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>    50    </u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/> <u>    80    </u></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>    80    </u></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		25		25
3	Classroom Wages (a)		385		385
4	Clinical Wages (b)		616		616
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		200		200
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 1,226	\$	\$ 1,226
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	1,226		

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$     None    

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	<u>    1    </u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<u>    1    </u>

- (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.

**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		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	<b>TOTAL</b>			\$ 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 CNAs, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number Randolph House

# 0031633

Report Period Beginning: 01/01/05

Ending:

12/31/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 187,566	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	43,871		3
4	Supply Inventory (priced at <u>cost</u> )	2,471		4
5	Short-Term Investments			5
6	Prepaid Insurance	9,738		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>DT Receivable</u>	45,570		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 289,216	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 289,216	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 22,591	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	4,088		30
31	Accrued Taxes Payable (excluding real estate taxes)	390		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,974		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 33,043	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>DT Payable</u>	57,565		43
44	<u>SEP Payable</u>	37,162		44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 94,727	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 127,770	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 161,446	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 289,216	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>127,087</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2004 SEP paid in 2005 to Owner</b>	(15,285)	<b>3</b>
<b>4</b>	<b>Add'l SEP paid in 2005 to Owner</b>	(5,824)	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>105,978</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	55,468	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>55,468</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>161,446</b>	<b>24</b> *

\* This must agree with page 17, line 47.

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

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

**1**

Revenue		Amount	
<b>A. Inpatient Care</b>			
<b>1</b>	Gross Revenue -- All Levels of Care	\$ <b>599,343</b>	<b>1</b>
<b>2</b>	Discounts and Allowances for all Levels	( )	<b>2</b>
<b>3</b>	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ <b>599,343</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
<b>4</b>	Day Care		<b>4</b>
<b>5</b>	Other Care for Outpatients		<b>5</b>
<b>6</b>	Therapy		<b>6</b>
<b>7</b>	Oxygen		<b>7</b>
<b>8</b>	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	<b>8</b>
<b>C. Other Operating Revenue</b>			
<b>9</b>	Payments for Education		<b>9</b>
<b>10</b>	Other Government Grants		<b>10</b>
<b>11</b>	CNA Training Reimbursements	<b>1,496</b>	<b>11</b>
<b>12</b>	Gift and Coffee Shop		<b>12</b>
<b>13</b>	Barber and Beauty Care		<b>13</b>
<b>14</b>	Non-Patient Meals		<b>14</b>
<b>15</b>	Telephone, Television and Radio		<b>15</b>
<b>16</b>	Rental of Facility Space		<b>16</b>
<b>17</b>	Sale of Drugs		<b>17</b>
<b>18</b>	Sale of Supplies to Non-Patients		<b>18</b>
<b>19</b>	Laboratory		<b>19</b>
<b>20</b>	Radiology and X-Ray		<b>20</b>
<b>21</b>	Other Medical Services	<b>1,276</b>	<b>21</b>
<b>22</b>	Laundry		<b>22</b>
<b>23</b>	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ <b>2,772</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
<b>24</b>	Contributions		<b>24</b>
<b>25</b>	Interest and Other Investment Income***	<b>752</b>	<b>25</b>
<b>26</b>	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ <b>752</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
<b>27</b>	<b>Settlement Income (Insurance, Legal, Etc.)</b>		<b>27</b>
<b>28</b>			<b>28</b>
<b>28a</b>			<b>28a</b>
<b>29</b>	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	<b>29</b>
<b>30</b>	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ <b>602,867</b>	<b>30</b>

**2**

Expenses		Amount	
<b>A. Operating Expenses</b>			
<b>31</b>	General Services	<b>118,015</b>	<b>31</b>
<b>32</b>	Health Care	<b>142,943</b>	<b>32</b>
<b>33</b>	General Administration	<b>189,533</b>	<b>33</b>
<b>B. Capital Expense</b>			
<b>34</b>	Ownership	<b>60,686</b>	<b>34</b>
<b>C. Ancillary Expense</b>			
<b>35</b>	Special Cost Centers		<b>35</b>
<b>36</b>	Provider Participation Fee	<b>36,222</b>	<b>36</b>
<b>D. Other Expenses (specify):</b>			
<b>37</b>			<b>37</b>
<b>38</b>			<b>38</b>
<b>39</b>			<b>39</b>
<b>40</b>	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ <b>547,399</b>	<b>40</b>
<b>41</b>	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>55,468</b>	<b>41</b>
<b>42</b>	<b>Income Taxes</b>		<b>42</b>
<b>43</b>	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ <b>55,468</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return?     No     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.

Facility Name & ID Number Randolph House

# 0031633

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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	31	558	18.00	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	482	5,376	10.14	9
10	Activity Assistants	1,796	12,341	6.75	10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook	1,386	14,919	10.18	14
15	Cook Helpers/Assistants	2,076	17,835	8.36	15
16	Dishwashers				16
17	Maintenance Workers	455	5,156	11.09	17
18	Housekeepers	1,401	12,629	8.61	18
19	Laundry	315	2,661	8.45	19
20	Administrator	200	1,304	6.27	20
21	Assistant Administrator	903	20,292	21.61	21
22	Other Administrative				22
23	Office Manager	502	7,318	14.02	23
24	Clerical	642	7,026	10.27	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)	11,322	101,179	8.50	30
31	Medical Records				31
32	Other Health C: <u>H.A. Trainer</u>				32
33	Other(specify) <u>H.A.Trainee</u>	130	1,001	7.70	33
34	TOTAL (lines 1 - 33)	21,641	22,617	\$ 209,595 *	\$ 9.27 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	23	\$ 1,202	L1 C3 35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant	437	8,033	L10 C3 38
39	Pharmacist Consultant	6	300	L10 C3 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	8	436	L10 C3 43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	<u>Physician Consultant</u>	24	3,000	L10 C3 47
48	<u>Psychological Consultant</u>	29	2,050	L10 C3 48
49	TOTAL (lines 35 - 48)	527	\$ 15,021	49

**C. CONTRACT NURSES**

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

Facility Name & ID Number **Randolph House**

# **0031633**

Report Period Beginning: **01/01/05**

Ending: **12/31/05**

**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		
Charlotte Watton	L.N.H.A.	0%	\$ 1,304	Workers' Compensation Insurance	\$ 5,692	IDPH License Fee	\$		
Carolyn Mays	Asst. Admn.	0%	20,292	Unemployment Compensation Insurance	2,405	Advertising: Employee Recruitment			
				FICA Taxes	16,034	Health Care Worker Background Check	20		
				Employee Health Insurance	29,087	(Indicate # of checks performed <u>1</u> )			
				Employee Meals	932	Vehicle License Fee	143		
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions	0		
				SEP/IRA Fund for Employees (See Page 21A)	35,971	Funeral Flowers	35		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 21,596	TOTAL (agree to Schedule V, line 22, col.8)		\$ 90,121	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 163	
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			\$ 41,600	None		\$	Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 41,600	TOTAL		\$ 0	In-State Travel		
C. Professional Services							Seminar Expense		
Vendor/Payee	Type		Amount						
Krehbiel & Associates	Cost Report Adjustments		\$ 1,275						
Ill. Dept of Pub. Health	CLIA Program certificate of waiver		150						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 1,425				Entertainment Expense (agree to Sch. V, line 24, col. 8)		
							TOTAL		\$ 0

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2002	FY2003	FY2004	FY2005
1	Roof Repairs	April, 2003	\$ 9,500	*3+	\$	\$ 1,899	\$ 2,534	\$ 2,534	\$ 2,534	\$	\$	\$								
2	Painting	May, 2004	7,541	*2+			1,885	2,828	2,828											
3																				
4																				
5																				
6																				
7				*Lease expires 12/15/06																
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>		\$ 17,041		\$	\$ 1,899	\$ 4,419	\$ 5,362	\$ 5,362	\$	\$	\$								

Facility Name & ID Number Randolph House# 0031633

Report Period Beginning:

01/01/05

Ending:

12/31/05**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? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 36,222  
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, 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. \$ 1,276  
c. What percent of all travel expense relates to transportation of nurses and patients? 27%  
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 Transportation

Mileage reimbursed to Char Watton, L.N.H.A., Q.M.R.P., M.S.W., from her management office in Shelbyville to Randolph House was \$8,622. Mrs. Watton is the administrator of two ICF-DD's and is a consultant for other facilities. She is scheduled to come to Randolph House as needed. Mileage logs have been maintained by Mrs. Watton and she bills the facility monthly for her travel.

Mileage reimbursed to the R.N. Consultant from her office in Marion County to Randolph House. She is scheduled to come to Randolph House as needed. Mileage logs have been maintained by the Consultant and she bills the facility monthly for her travel.

	Watton	\$ 8,622.00
	R.N.	<u>\$ 1,930.00</u>
Total	L25 C4	\$ 10,552.00

According to the 15-passenger van mileage log, 10,325 miles were driven during this fiscal year (104,631 less 94,306.) Of that, 5,358 miles were for unloaded errand miles for the facility. Therefore:  
 $(5,358 \text{ miles} / 10,325 \text{ miles}) \times \$2973 = \$1543$

		<u>\$ 1,543.00</u>
Total	L25 C8	\$ 12,095.00

Adjustments

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 Transportation	\$ 855.00	
	Line 14 Program Transportation		\$ 855.00

To re-classify so that Line 38 will equal \$855, the amount accrued for medically necessary transportation.

C

Line 23	Inservice Training and Education	\$ 256.00	
	Line 10 Nursing and Medical Records		\$ 86.00
	Line 17 Administrative		\$ 170.00

To re-classify for in-services as follows:

Char Watton, L.N.H.A., M.S.W., Q.M.R.P., on 1/11/05 and 10/11/05  
Carolyn Mays, Asst. Admn., on 6/17/05, 11/13/05, and 12/13/05  
Kim Allsop, R.N., on 11/18/05

D

Line 25	Other Admn. Staff Transportation	\$ 1,543.00	
	Line 14 Program Transportation		\$ 1,543.00

According to the 15-passenger van mileage log, 10,325 miles were driven this fiscal year (104,631 less 94,306.) Of that, 5,358 miles were unloaded errand miles for the facility. Therefore,

Line 25 Other Admn. Travel = (5,358 miles/10,325 miles) x \$2973 = \$1543.

E

Line 25	H.A. Training	\$ 200.00	
	Line 10 Nursing and Medical Records		\$ 200.00

To re-classify H.A.T. instructor pay to Habilitation Aide Training.

Income Tax Return	Gross Revenue (includes DT)	\$ 873,112.33
	Total Expenses (includes DT)	<u>\$ 659,553.73</u>
Income Tax Return Net Income (Cash Basis)		\$ 213,558.60
Plus:		
12/31/05 Difference in DT Expense	\$ 31,994.98	
12/31/05 H.A.T. Receivable	\$ 1,496.00	
12/31/05 Difference in A/P	\$ 31.16	
12/31/05 Difference in Insurance Expense	<u>\$ 6,596.77</u>	
Total Additions		\$ 40,118.91
Less:		
12/31/05 Difference in A/R for Clients	\$ 102,120.00	
12/31/05 Difference in DT Revenue	\$ 31,994.98	
12/31/05 Difference in A/R for Transportation	\$ 769.75	
12/31/05 A/P for Accy. Fees	\$ 1,275.00	
R.E. Tax Expense Difference	\$ 531.56	
Owners' SEP Payment	\$ 19,918.00	
Owners' Contractual Pay	<u>\$ 41,600.00</u>	
Total Deductions		<u>\$ (198,209.29)</u>
Cost Report Net Income (Accrual Basis)		\$ 55,468.22

<u>Employee</u>	<u>Hire Date</u>	<u>SEP Contribution</u>
Asbury, Lucille	8/28/2001	\$ 1,389.00
Beck, Goldie	9/28/1994	\$ 1,629.00
Blankenship, Viola	11/30/2000	\$ 1,682.00
Edwards, Josephine	7/11/1986	\$ 1,482.00
George, Cathy	12/10/1996	\$ 1,608.00
Gipson, Roger	1/14/2002	\$ 1,587.00
Mays, Carolyn	7/11/1986	\$ 3,520.00
Mays, Margarita	4/1/1997	\$ 1,874.00
Watton, Charlotte	1/1/1987	\$ 130.00
White, Kimberly	6/6/1995	<u>\$ 1,152.00</u>
Total Excluding Owner		\$ 16,053.00
Armbrust, Rita (Owner)		<u>\$ 19,918.00</u>
Total Including Owner		\$ 35,971.00

12. Carolyn Mays

Assistant Administrator	\$ 20,292.00
Dietary	\$ 614.00
Housekeeping	\$ 3,071.00
Maintenance	\$ 3,071.00
Clerical	\$ 908.00
Office Manager	<u>\$ 7,318.00</u>
 Total Wages	 \$ 35,274.00