

Facility Name & ID Number Randolph House

0031633 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,451			5,451	13
14	TOTALS	5,451			5,451	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.34%

D. How many bed-hold days during this year were paid by the Department? 98 (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: 12/31/06 Fiscal Year: 12/31/06

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

STATE OF ILLINOIS

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	34,813	3,235	1,365	39,413		39,413		39,413		1
2	Food Purchase		40,779		40,779	(932)	39,847		39,847		2
3	Housekeeping	12,941	5,849		18,790		18,790		18,790		3
4	Laundry	3,079	1,152		4,231		4,231		4,231		4
5	Heat and Other Utilities			12,049	12,049		12,049		12,049		5
6	Maintenance	5,597	3,318	3,108	12,023		12,023	5,362	17,385		6
7	Other (specify):* Garbage			1,652	1,652		1,652		1,652		7
8	TOTAL General Services	56,430	54,333	18,174	128,937	(932)	128,005	5,362	133,367		8
B. Health Care and Programs											
9	Medical Director										9
10	Nursing and Medical Records	107,094	3,128	8,144	118,366	(36)	118,330		118,330		10
10a	Therapy										10a
11	Activities	17,006	1,023	924	18,953		18,953		18,953		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation		2,791	1,286	4,077	(1,777)	2,300		2,300		14
15	Other (specify):* Hab Aide Training	2,084	50		2,134		2,134		2,134		15
16	TOTAL Health Care and Programs	126,184	6,992	10,354	143,530	(1,813)	141,717		141,717		16
C. General Administration											
17	Administrative	29,265		41,600	70,865	(79)	70,786		70,786		17
18	Directors Fees										18
19	Professional Services			1,248	1,248		1,248		1,248		19
20	Dues, Fees, Subscriptions & Promotions			911	911		911		911		20
21	Clerical & General Office Expenses	10,675	2,639	2,610	15,924		15,924		15,924		21
22	Employee Benefits & Payroll Taxes			53,659	53,659	932	54,591		54,591		22
23	Inservice Training & Education			226	226	115	341		341		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			8,588	8,588	375	8,963		8,963		25
26	Insurance-Prop.Liab.Malpractice			5,404	5,404		5,404		5,404		26
27	Other (specify):*										27
28	TOTAL General Administration	39,940	2,639	114,246	156,825	1,343	158,168		158,168		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	222,554	63,964	142,774	429,292	(1,402)	427,890	5,362	433,252		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.

Facility Name & ID Number

Randolph House

#0031633

Report Period Beginning:

01/01/06

Ending:

12/31/06

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			364	364		364		364			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			6,402	6,402		6,402		6,402			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			60,946	60,946		60,946		60,946			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,402	1,402		1,402			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,644	35,644		35,644		35,644			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			35,644	35,644	1,402	37,046		37,046			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	222,554	63,964	239,364	525,882		525,882	5,362	531,244			45

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

Facility Name & ID Number Randolph House

0031633

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	CNA 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

BHF USE ONLY						
48		49	50	51	52	

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

		1	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		\$ 1,402	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)			\$ 1,402		47

Randolph House

ID# 0031633

Report Period Beginning: 01/01/06

Ending: 12/31/06

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

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	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.

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	*39,107	20	50.00	Contractual	\$ 41,600	L17 C3	1
2											2
3											3
4											4
5					*Reservoir Manor						5
6											6
7											7
8											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

Facility Name & ID Number Randolph House # 0031633 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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	32	2	1440	\$ 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

Facility Name & ID Number **Randolph House** # **0031633** Report Period Beginning: **01/01/06** Ending: **12/31/06**

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

2005 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 Costs

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of total cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(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. <u>182-14-00-500-508</u>	<u>All Bldg 62</u>	\$ <u>6,188.42</u>	\$ <u>6,188.42</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>6,188.42</u>	\$ <u>6,188.42</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 directly 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 home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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

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 ground (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>			\$	1
2					2
3	TOTALS	<u>None</u>		\$	3

Facility Name & ID Number Randolph House

0031633

Report Period Beginning:

 01/01/06

Ending:

 12/31/06

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 BHF 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
Improvement Type**									
9	Asphalt Parking Lot		1987	2,420		10			2,420
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

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
	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	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

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	GMC Suburban, 1998	2006	\$ 5,830	\$ 364	\$ 364	\$	4	\$ 364	76
77										77
78										78
79										79
80	TOTALS			\$ 5,830	\$ 364	\$ 364	\$		\$ 364	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 15,089	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 364	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 364	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,623	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	None	\$	\$	\$	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? YES NO
If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	7
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	16		\$ 54,180			7

10. Effective dates of current rental agreement:
Beginning 12/15/86
Ending 03/31/07

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2007</u>	\$ <u>15,525</u>
13.	<u>12/31/2008</u>	\$ <u>720</u>
14.	<u>12/31/2009</u>	\$ <u>720</u>

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		\$ 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.

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies		50		50
3 Classroom Wages (a)		725		725
4 Clinical Wages (b)		1,159		1,159
5 In-House Trainer Wages (c)		200		200
6 Transportation				
7 Contractual Payments				
8 CNA Competency Tests				
9 TOTALS	\$	\$ 2,134	\$	\$ 2,134
10 SUM OF line 9, col. 1 and 2 (e)	\$	2,134		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$ None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

- (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	TOTAL			\$ 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.

STATE OF ILLINOIS

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Facility Name & ID Number Randolph House

0031633

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 16,455	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	146,106		3
4	Supply Inventory (priced at cost)	2,532		4
5	Short-Term Investments			5
6	Prepaid Insurance	11,293		6
7	Other Prepaid Expenses	78		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 176,464	\$	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	12,669		16
17	Accumulated Depreciation (book methods)	(9,623)		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)	\$ 5,466	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 181,930	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 19,768	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,000		29
30	Accrued Salaries Payable	4,657		30
31	Accrued Taxes Payable (excluding real estate taxes)	445		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,188		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 41,058	\$	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)	\$ 41,058	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 140,872	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 181,930	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 161,446	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 161,446	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	84,426	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	(105,000)	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)	\$ (20,574)	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)	\$ 140,872	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Randolph House

0031633

Report Period Beginning: 01/01/06

Ending:

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12/31/06

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	\$ 605,652	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 605,652	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	CNA 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	1,402	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,402	23
D. Non-Operating Revenue			
24	Contributions	575	24
25	Interest and Other Investment Income***	1,179	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,754	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on Sale of Van	1,500	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,500	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 610,308	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	128,937	31
32	Health Care	143,530	32
33	General Administration	156,825	33
B. Capital Expense			
34	Ownership	60,946	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	35,644	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 525,882	40
41	Income before Income Taxes (line 30 minus line 40)**	84,426	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 84,426	43

* 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: 01/01/06

Ending: 12/31/06

12/31/06

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			\$	\$	1
2					2
3	219	219	4,659	21.27	3
4					4
5					5
6					6
7					7
8					8
9	980	1,068	8,911	8.34	9
10	1,049	1,049	8,095	7.72	10
11					11
12					12
13					13
14	1,481	1,481	15,404	10.40	14
15	2,269	2,269	19,409	8.55	15
16					16
17	440	440	5,597	12.72	17
18	1,285	1,285	12,941	10.07	18
19	322	322	3,079	9.56	19
20	200	208	1,304	6.27	20
21	1,000	1,004	15,770	15.71	21
22	1,040	1,040	12,191	11.72	22
23	280	303	4,252	14.03	23
24	602	626	6,423	10.26	24
25					25
26					26
27					27
28					28
29					29
30	11,906	12,450	102,435	8.23	30
31					31
32	260	260	1,884	7.25	32
33	20	20	200	10.00	33
34	23,353	24,044	\$ 222,554 *	\$ 9.26	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	27	\$ 1,365	L1 C3	35
36				36
37				37
38	158	2,844	L10 C3	38
39	4	200	L20 C3	39
40				40
41				41
42				42
43	10	528	L10 C3	43
44				44
45				45
46	24	3,000	L10 C3	46
47	10	750	L10 C3	47
48				48
49	233	\$ 8,687		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50		\$		50
51				51
52				52
53		\$ 0		53

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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
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												
8				*Lease expires 3/15/07								
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 17,041		\$ 1,899	\$ 4,419	\$ 5,362	\$ 5,362	\$	\$	\$	\$

Facility Name & ID Number Randolph House# 0031633Report Period Beginning: 01/01/06Ending: 12/31/06**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 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. \$ 431 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (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. \$ 35,644
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 benefit: 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. \$ 1,402
c. What percent of all travel expense relates to transportation of nurses and patients? 29.23%
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 \$5,000, 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 \$7,757. 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 was \$782.

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		\$7,757
R.N.		\$782
Mileage Pd for Client Screening		<u>\$49</u>
Total	L25 C4	\$8,588

According to the facility's mileage log, 10,813 miles were driven during this fiscal year (old 15-passenger van: 112,305 less 104,631; plus Suburban: 49,556 less 46,417.)

Of that, 1,054 miles were for unloaded errand miles for the facility. Therefore,

$(1,054 \text{ miles} / 10,813 \text{ miles}) \times \$3749 = \$375$

		<u>\$375</u>
Total	L25 C8	\$8,963

§7757.
as needed.

		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		\$ 1,402.00	
	Line 14	Program Transportation		\$ 1,402.00

To re-classify so that Line 38 will equal \$1402, the amount accrued for medically necessary transportation.

		C		
Line 23	Inservice Training and Education		\$ 115.00	
	Line 10	Nursing and Medical Records		\$ 36.00
	Line 17	Administrative		\$ 79.00

To re-classify inservices as follows:

Char Watton, L.N.H.A., M.S.W., Q.M.R.P., on 3/20/06, 5/30/06 & 7/25/06
 Carolyn Mays, Asst. Admn., on 5/30/06
 Cindy Bennett, R.N., on 9/22/06 and 9/23/06

		D		
Line 25	Other Admn. Staff Transportation		\$ 375.00	
	Line 14	Program Transportation		\$ 375.00

According the facility's mileage log, 10,813 miles were driven during this fiscal year (old passenger van: 112,305 less 104,631; plus Suburban: 49,556 less 46,417.) Of that, 1054 miles were for unloaded errand miles for the facility. Therefore: Line 25 Other Admn. Travel = (1,054 miles/10,813 miles) x \$3749 = \$375

12. Carolyn Mays	
Assistant Administrator	\$ 12,191.00
Dietary	\$ 342.00
Housekeeping	\$ 1,708.00
Maintenance	\$ 1,708.00
Clerical	\$ 1,000.00
Office Manager	<u>\$ 4,252.00</u>
 Total Wages	 \$ 21,201.00
 12. R.N.	
R.N.	\$ 4,659.00
Hab. Aide Trainer	<u>\$ 200.00</u>
 Total Wages	 \$ 4,859.00

Income Tax Return	Gross Revenue (Includes DT)	\$ 632,544.00
	Total Expenses (Includes DT)	<u>\$ 625,639.00</u>
Income Tax Return Net Income (Cash Basis)		\$ 6,905.00
Plus:	12/31/06 Difference in DT A/P	\$ 18,030.00
	12/31/06 Difference in A/R for Clients	\$ 103,183.00
	12/31/06 Difference in Prepaid Insurance	\$ 1,555.00
	12/31/06 Difference in A/R for Transportation	\$ 581.00
	12/31/06 Difference in Prepaid Expense	\$ 78.00
	12/31/06 Difference in SEP Payable	\$ 14,799.00
	12/31/06 Difference in H.A.T. Receivable	<u>\$ 1,496.00</u>
Total Additions		\$ 139,722.00
Less:	12/31/06 Difference in DT A/R	\$ 18,030.00
	12/31/06 Difference in A/P	\$ 1,734.00
	12/31/06 Difference in Salaries Payable	\$ 569.00
	12/31/06 Difference in R.E. Taxes Payable	\$ 214.00
	12/31/06 Difference in P/R Taxes Payable	\$ 54.00
	Owners' Contractual Pay	<u>\$ 41,600.00</u>
Total Deductions		<u>\$ (62,201.00)</u>
Cost Report Net Income (Accrual Basis)		\$ 84,426.00