

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0007781

Facility Name: Columbus Manor Residential Care Home Inc

Address: 5107 W Jackson Blvd Chicago 60644
Number City Zip Code

County: Cook

Telephone Number: 773-378-5490 Fax # 773-378-7890

HFS ID Number:

Date of Initial License for Current Owners: June 17, 1999

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Patrick J O'Brien Telephone Number: 773-378-5490
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) Patrick J O'Brien
(Title) Administrator

Paid
Preparer

(Signed)
(Print Name and Title) See Attached Compilation Report
(Firm Name & Address) Zoller, Swanson & Co CPAs
137 N Oak Park Ave, Suite 320, Oak Park, IL 60301
(Telephone) 708-848-3296 Fax # 708-763-8852

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

Facility Name & ID Number Columbus Manor Residential Care Home Inc

0007781 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	189	Intermediate (ICF)	189	68,985	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	189	TOTALS	189	68,985	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	40,698			40,698	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,698			40,698	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.00%

D. How many bed-hold days during this year were paid by the Department? (809) (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 0/0/66

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 5/1/79 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 None

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

STATE OF ILLINOIS												
Facility Name & ID Number		Columbus Manor Residential Care Home Inc				#	0007781	Report Period Beginning:		1/1/11	Ending:	Page 3 12/31/11
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)												
	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	180,635	19,429	10,309	210,373		210,373		210,373			1
2	Food Purchase		220,842		220,842	(17,115)	203,727		203,727			2
3	Housekeeping	75,978	23,636	795	100,409		100,409		100,409			3
4	Laundry	36,631	8,732	1,545	46,908		46,908		46,908			4
5	Heat and Other Utilities			117,023	117,023		117,023		117,023			5
6	Maintenance	74,884	15,472	166,381	256,737		256,737		256,737			6
7	Other (specify):*											7
8	TOTAL General Services	368,128	288,111	296,053	952,292	(17,115)	935,177		935,177			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	847,987	34,396	11,424	893,807		893,807		893,807			10
10a	Therapy											10a
11	Activities	46,668	1,102	21,730	69,500		69,500		69,500			11
12	Social Services	122,912		3,869	126,781		126,781		126,781			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,017,567	35,498	37,023	1,090,088		1,090,088		1,090,088			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services			151,740	151,740		151,740		151,740			19
20	Dues, Fees, Subscriptions & Promotions			7,240	7,240		7,240	(2,290)	4,950			20
21	Clerical & General Office Expenses	73,706	4,543	13,298	91,547		91,547	(4,543)	87,004			21
22	Employee Benefits & Payroll Taxes			194,483	194,483	19,604	214,087		214,087			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,220	1,220		1,220		1,220			24
25	Other Admin. Staff Transportation			18,516	18,516	2,552	21,068	(900)	20,168			25
26	Insurance-Prop.Liab.Malpractice			85,382	85,382	(5,041)	80,341		80,341			26
27	Other (specify):* Contributions & Fines			23,414	23,414		23,414	(37,654)	(14,240)			27
28	TOTAL General Administration	73,706	4,543	495,293	573,542	17,115	590,657	(45,387)	545,270			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,459,401	328,152	828,369	2,615,922		2,615,922	(45,387)	2,570,535			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			53,935	53,935		53,935	13,333	67,268			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,240	14,240		14,240	51,418	65,658			32
33	Real Estate Taxes			187,794	187,794		187,794		187,794			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* IL Replacement Tax			2,007	2,007		2,007	(2,007)				36
37	TOTAL Ownership			737,976	737,976		737,976	(417,256)	320,720			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		13,117	5,000	18,117		18,117		18,117			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,000	108,000		108,000		108,000			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		13,117	113,000	126,117		126,117		126,117			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,459,401	341,269	1,679,345	3,480,015		3,480,015	(462,643)	3,017,372			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	(4,543)	21		13
14	Non-Care Related Interest	(14,240)	27		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(900)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(17,864)	27		18
19	Entertainment				19
20	Contributions	(5,550)	27		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	(2,007)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,290)	21		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,394)		\$	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(415,249)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (415,249)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (462,643)		37

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

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

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

Report Period Beginning: ID# 0007781

Ending: 1/1/11

12/31/11

Sch. V Line

Reference

NON-ALLOWABLE EXPENSES		Amount		
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

Summary A

12/31/11

[illegible]

Summary B

12/31/11

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Patrick J O'Brien	50					
Daniel J O'Brien	50					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 480,000	CM LLC	0.00%	\$	(480,000)	1
2	V	30	Depreciation		CM LLC	0.00%	13,333	13,333	2
3	V	32	Interest		CM LLC	0.00%	22,385	22,385	3
4	V	32	Loan Expense		CM LLC	0.00%	29,033	29,033	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			\$ 480,000			\$ 64,751	\$ * (415,249)	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

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	Patrick J O'Brien	Administrator	CEO Administrator	50.00	0	40	100.00		\$ 0		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Columbus Manor Residential Care Home Inc # 0007781 Report Period Beginning: 1/1/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Lightstar Financial		X	Revolving Credit	varies	varies	\$ 314,438	\$ 120,000	varies	0.0262	\$ 14,240	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 314,438	\$ 120,000			\$ 14,240	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 314,438	\$ 120,000			\$ 14,240	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.		\$	181,028	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	94,824	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(86,204)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	273,998	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	187,794	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	79,182	8	
		2007	153,168	9	
		2008	148,043	10	
		2009	172,407	11	
		2010	179,913	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2010 \$
				14	PLUS APPEAL COST FROM LINE 5 \$
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

- 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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Columbus Manor Residential Care Home Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0007781

CONTACT PERSON REGARDING THIS REPORT Patrick J O'Brien

TELEPHONE 773-378-5490 FAX #: 773-378-7890

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>16-16-222-019-0000</u>	<u>5107 W Jackson Boulevard</u>	\$ <u>179,913.00</u>	\$ <u>179,913.00</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>179,913.00</u></u>	\$ <u><u>179,913.00</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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:

41,308

B. General Construction Type:

Exterior

Brick

Frame

Fire Resistant

Number of Stories

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).

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	Building Site	41,988	1965-1978	\$ 34,000	1
2					2
3	TOTALS	41,988		\$ 34,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	129		1965	1955	\$ 179,090	\$	30	\$	\$	179,090
5	12			1969	67,135		30			67,135
6	48		1969	1973	401,170		30			401,170
7										
8										
	Improvement Type**									
9	Sidewalk		1966		1,309		20			1,309
10	Sidewalk		1967		1,819		20			1,819
11	Fence		1970		5,795		15			5,795
12	Remodeling		1970		26,600		30			26,600
13	Sprinkler System		1971		39,406		25			39,406
14	Tile Flooring		1971		12,097		20			12,097
15	Additions		1972		89,417		30			89,417
16	Stairs Porch Enclosed		1972		19,211		30			19,211
17	Roofing Replaced		1972		3,783		30			3,783
18	Canopy		1972		1,339		20			1,339
19	Fencing		1972		2,016		15			2,016
20	Tile Floors		1973		4,718		20			4,718
21	Additions		1974		30,006		30			30,006
22	Chain Link Fence		1974		3,589		15			3,589
23	Sprinkler System		1974		4,664		25			4,664
24	Nurses Station		1975		15,635		20			15,635
25	Switching Tiling		1975		13,706		20			13,706
26	Additions		1976		14,351		30			14,351
27	Plumbing and Heating		1976		20,000		25			20,000
28	Tiles and Toilets		1976		39,685		20			39,685
29	Sprinkler System		1976		1,868		25			1,868
30	Tops and Caulking		1976		52,683		20			52,683
31	Tile		1976		6,796		20			6,796
32	Retile Building		1977		53,525		20			53,525
33	Plastering		1977		10,920		20			10,920
34	Carpentry		1978		5,152		20			5,152
35	Tile		1978		11,775		20			11,775
36	Tuckpointing		1980		5,600		20			5,600

*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

Facility Name & ID Number Columbus Manor Residentail Care Home, Inc

7781

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Hot Water Heater	1981	\$ 971	\$	10	\$	\$	\$ 971	37
38	Doors, etc.	1981	1,360		20			1,360	38
39	Ceramic Tile	1981	24,262		20			24,262	39
40	Additions	1982	14,743		20			14,743	40
41	Windows	1983	13,166		20			13,166	41
42	Windows	1987	2,365		20			2,365	42
43	Cameras	1987	1,091		20			1,091	43
44	Roof Improvement	1988	3,700		20			3,700	44
45	Heater	1990	1,240		10			1,240	45
46	Doors, etc.	1990	3,543	87	20	87		3,543	46
47	Electrical	1990	2,202	54	20	54		2,202	47
48	Exit Doors	1991	19,211	475	20	475		19,211	48
49	Doors, etc.	1991	14,655	363	20	363		14,655	49
50	Electrical	1991	3,507	92	20	92		3,507	50
51	New Door	1992	1,330	67	20	67		1,303	51
52	Roof Improvement	1992	8,950	448	20	448		8,733	52
53	Windows	1992	3,150	158	20	158		3,078	53
54	Exit/Interior Doors	1993	6,100	305	20	305		5,339	54
55	Remodel Nurse's Station	1994	16,000	800	20	800		14,400	55
56	Outside Door	1994	2,882	144	20	144		2,593	56
57	Remodel Nurse's Station	1994	20,300	1,015	20	1,015		18,270	57
58	Roof Replacement	1995	28,751	1,438	20	1,438		24,444	58
59	Remodel Nurse's Station	1995	17,710	886	20	886		15,060	59
60	Generator	1998	80,000		10			80,000	60
61	Air Conditioner/Monitor	1998	2,098		10			2,098	61
62	Hydra Electric	1999	900		10			900	62
63	DeCarlo Construction	1999	4,900	245	20	245		3,185	63
64	Storm Windows	1999	6,059	303	20	303		3,939	64
65	Wall Repair	1999	3,098	155	20	155		2,015	65
66	AC Prep	1999	1,824	92	20	92		1,196	66
67	New Fans	1999	1,932	97	20	97		1,261	67
68	AC Prep	1999	2,168	109	20	109		1,417	68
69	Exhaust Fans	1999	9,450	473	20	473		6,149	69
70	TOTAL (lines 4 thru 69)		\$ 1,468,478	\$ 7,806		\$ 7,806	\$	\$ 1,446,256	70

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

Facility Name & ID Number Columbus Manor Residentail Care Home, Inc

7781

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,468,478	\$ 7,806		\$ 7,806	\$	\$ 1,446,256	1
2	<u>Radiator</u>	2000	10,900	545	20	545		6,540	2
3	<u>PTAK Unit</u>	2000	8,606	431	20	431		5,164	3
4	<u>Four Baseboard Heaters</u>	2001	1,778	89	20	89		935	4
5	<u>Nursing Department Cabinets</u>	2006	5,948	298	20	298		2,914	5
6	<u>Front Sign</u>	2007	6,889	460	15	460		2,070	6
7	<u>New Doors</u>	2007	13,676	912	15	912		4,104	7
8	<u>Plumbing Upgrades</u>	2007	8,580	572	15	572		2,301	8
9	<u>New Patio</u>	2007	2,200	147	15	147		662	9
10	<u>Heating Improvements</u>	2007	4,400	294	15	294		1,323	10
11	<u>Courtyard Improvements</u>	2007	9,328	622	15	622		2,799	11
12	<u>11 New Windows</u>	2008	8,371	419	20	419		1,466	12
13	<u>38 New Windows</u>	2008	30,400	1,520	20	1,520		5,320	13
14	<u>New Doors</u>	2008	786	40	20	40		140	14
15	<u>Door Closers</u>	2008	2,549	128	20	128		448	15
16	<u>Fire Alarm Replacement</u>	2008	99,423	4,972	20	4,972		17,402	16
17	<u>Emergency Lighting</u>	2008	20,000	1,000	20	1,000		3,500	17
18	<u>3 Sprinkler Heads</u>	2009	1,890	126	15	126		315	18
19	<u>Roof Repairs</u>	2009	3,500	234	15	234		585	19
20	<u>Basement Drywall Repair and Painting</u>	2009	4,145	276	15	276		690	20
21	<u>Tile Floor</u>	2009	2,900	194	15	194		485	21
22	<u>2 Exterior Doors</u>	2009	4,629	309	15	309		773	22
23	<u>2 Exterior Doors</u>	2009	4,017	268	15	268		670	23
24	<u>4 New Windows</u>	2009	1,756	117	15	117		293	24
25	<u>Fire Alarm Improvements</u>	2009	5,939	396	15	396		990	25
26	<u>Dining Room Security Door</u>	2009	3,180	212	15	212		530	26
27	<u>Replace Subflooring and Tile in Three Bathrooms</u>	2010	9,176	230	20	230		460	27
28	<u>Replace Subflooring and Tile in One Bathroom</u>	2010	1,948	49	20	49		98	28
29	<u>18 Window Screens</u>	2010	526	26	10	26		52	29
30	<u>Public Phone Privacy Wall</u>	2010	742	19	20	19		38	30
31	<u>AC Installation</u>	2010	3,430	171	20	171		342	31
32	<u>Five new doors installed</u>	2011	4,455	223	10	223		223	32
33	<u>Five fire rated doors installed</u>	2011	6,700	335	10	335		335	33
34	TOTAL (lines 1 thru 33)		\$ 1,761,245	\$ 23,440		\$ 23,440	\$	\$ 1,510,223	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$1,761,245	\$23,440		\$23,440	\$	\$1,510,223	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	TOTAL (lines 1 thru 33)		\$1,761,245	\$23,440		\$23,440	\$	\$1,510,223	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$362,365	\$21,043	\$21,043	\$		\$259,537	71
72	Current Year Purchases	12,772	639	639				72
73	Fully Depreciated Assets	1,169,371					1,169,371	73
74								74
75	TOTALS	\$1,544,508	\$21,682	\$21,682	\$		\$1,428,908	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	Ford Crown Victoria 2003	2003	\$26,470	\$2,647	\$2,647	\$	10	\$22,499	76
77	Facility Business	Ford Fusion 2008	2007	33,307	6,662	6,662		5	29,979	77
78										78
79										79
80	TOTALS			\$59,777	\$9,309	\$9,309	\$		\$52,478	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)	\$3,399,530	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$54,431	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$54,431	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)	\$2,991,609	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	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

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

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: \$
- Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

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

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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 prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 24,230	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,317,876		3
4	Supply Inventory (priced at)	1,800		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,519		6
7	Other Prepaid Expenses	23,238		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,383,663	\$	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	1,028,904		15
16	Equipment, at Historical Cost	732,354		16
17	Accumulated Depreciation (book methods)	(1,329,819)		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)	\$ 431,439	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,815,102	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 236,533	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	139,684		29
30	Accrued Salaries Payable	24,500		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,909		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)	\$ 589,626	\$	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)	\$ 589,626	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,225,476	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,815,102	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 700,074	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 700,074	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,953,958	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	(428,556)	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)	\$ 1,525,402	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)	\$ 2,225,476	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,402,722	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,402,722	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	7,216	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,216	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,035	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,035	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,433,973	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	952,292	31
32	Health Care	1,090,088	32
33	General Administration	573,542	33
	B. Capital Expense		
34	Ownership	737,976	34
	C. Ancillary Expense		
35	Special Cost Centers	126,117	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,480,015	40
41	Income before Income Taxes (line 30 minus line 40)**	1,953,958	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,953,958	43

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

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

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	1,344	1,368	\$ 47,880	\$ 35.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,549	3,629	110,492	30.45	3
4	Licensed Practical Nurses	13,388	14,449	314,696	21.78	4
5	CNAs & Orderlies	32,745	34,906	317,905	9.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,951	4,295	47,313	11.02	10
11	Social Service Workers	6,772	7,268	123,064	16.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,610	14,757	180,220	12.21	15
16	Dishwashers					16
17	Maintenance Workers	3,569	4,037	74,984	18.57	17
18	Housekeepers	7,423	7,975	75,656	9.49	18
19	Laundry	3,847	4,151	36,631	8.82	19
20	Administrator	1,920	2,080		0.00	20
21	Assistant Administrator	1,856	1,973	64,386	32.63	21
22	Other Administrative	546	550	10,025	18.23	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,784	1,836	55,556	30.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,304	103,274	\$ 1,458,808 *	\$ 14.13	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 10,309		35
36	Medical Director				36
37	Medical Records Consultant		1,256		37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		5,095		44
45	Social Service Consultant		3,869		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 20,529		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)		\$		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Patrick J O'Brien	Administrator	0	\$ 0	Workers' Compensation Insurance		\$ 35,432	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance		45,068	Advertising: Employee Recruitment	110	
				FICA Taxes		111,525	Health Care Worker Background Check		
				Employee Health Insurance		2,489	(Indicate # of checks performed <u>1</u>)	250	
				Employee Meals		17,115	Patient Background Checks <u>60</u>	3,295	
				Illinois Municipal Retirement Fund (IMRF)*			Yellow Page Advertising	2,290	
				Chicago Department of Revenue - Head Tax		2,459	Sec of State Annual Report	100	
							Dept of Professional Regulators	100	
							Costco Business Membership	100	
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	()	
(List each licensed administrator separately.)							Non-allowable advertising	()	
							Yellow page advertising	(2,290)	
				</					

*** Attach copy of IMRF notifications**

****See instructions.**

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?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(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?

10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$N/ALine

(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?

YESXNO

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

YESNOX

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.

\$108,000

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

N/A

(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.

\$17,115

Has any meal income been offset against related costs?

N/A

Indicate the amount. \$

(16) Travel and Transportation

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

No

If YES, attach a complete explanation.

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

No

If YES, please indicate the amount of income earned from such a program during this reporting period. \$

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

N/A

d. Have vehicle usage logs been maintained?

No

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

No

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:

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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?

Yes

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