

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0007781</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Columbus Manor Residential Care Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> 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.																																																	
Address: <u>5107-21 West Jackson Boulevard</u> <u>Chicago</u> <u>60644</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
County: <u>Cook</u>																																																			
Telephone Number: <u>773-378-5490</u> Fax # <u>773-378-7890</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>June 17, 1999</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☒</td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td>☐</td><td>Other _____</td><td colspan="2"></td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____				
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		☐	Limited Liability Co.																																																
		☐	Trust																																																
		☐	Other _____																																																
In the event there are further questions about this report, please contact:																																																			
Name: <u>Patrick J O'Brien</u>																																																			
Telephone Number: <u>773-378-5490</u>																																																			
Email Address: _____																																																			
		Officer or Administrator of Provider																																																	
		(Signed) _____ (Date) _____																																																	
		(Type or Print Name) <u>Patrick J O'Brien</u>																																																	
		(Title) <u>Administrator</u>																																																	
		(Signed) _____ (Date) _____																																																	
		Paid Preparer																																																	
		(Print Name and Title) <u>See Attached Compilation Report</u>																																																	
		(Firm Name & Address) <u>Zoller Swanson & Co CPAs</u> <u>137 N Oak Park Ave Ste 320, Oak Park, IL 60301</u>																																																	
		(Telephone) <u>708-848-3296</u> Fax # <u>708-763-8852</u>																																																	
		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

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

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	2	3	4	5	
	Level of Care	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	39,376			39,376	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,376			39,376	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.08%

D. How many bed-hold days during this year were paid by the Department? 13 (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) _____

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

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/12 Fiscal Year: 12/31/12
* All facilities other than governmental must report on the accrual basis.

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

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	181,191	147	9,504	190,842		190,842		190,842			1
2	Food Purchase		313,606		313,606	(24,304)	289,302		289,302			2
3	Housekeeping	78,924		3,064	81,988		81,988		81,988			3
4	Laundry	36,659	8,120	1,871	46,650		46,650		46,650			4
5	Heat and Other Utilities			113,865	113,865		113,865		113,865			5
6	Maintenance	68,007	19,742	129,326	217,075		217,075		217,075			6
7	Other (specify):*											7
8	TOTAL General Services	364,781	341,615	257,630	964,026	(24,304)	939,722		939,722			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	775,968	36,699	20,149	832,816		832,816		832,816			10
10a	Therapy											10a
11	Activities	50,159	65	1,297	51,521		51,521		51,521			11
12	Social Services	100,805		1,331	102,136		102,136		102,136			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	926,932	36,764	22,777	986,473		986,473		986,473			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services			107,182	107,182		107,182		107,182			19
20	Dues, Fees, Subscriptions & Promotions			9,578	9,578		9,578	(2,698)	6,880			20
21	Clerical & General Office Expenses	47,228	3,796	32,657	83,681		83,681	(3,796)	79,885			21
22	Employee Benefits & Payroll Taxes			220,007	220,007	29,078	249,085		249,085			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,240	2,240		2,240		2,240			24
25	Other Admin. Staff Transportation			16,596	16,596	3,500	20,096	(2,010)	18,086			25
26	Insurance-Prop.Liab.Malpractice			112,186	112,186	(8,274)	103,912		103,912			26
27	Other (specify):*			127,297	127,297		127,297	(168,228)	(40,931)			27
28	TOTAL General Administration	47,228	3,796	627,743	678,767	24,304	703,071	(176,732)	526,339			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,338,941	382,175	908,150	2,629,266		2,629,266	(176,732)	2,452,534			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			61,576	61,576		61,576	13,333	74,909			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,437	43,437		43,437	29,035	72,472			32
33	Real Estate Taxes			178,379	178,379		178,379		178,379			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			8,505	8,505		8,505	(8,505)				36
37	TOTAL Ownership			771,897	771,897		771,897	(446,137)	325,760			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,695	874	9,569		9,569		9,569			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,400	104,400		104,400		104,400			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		8,695	105,274	113,969		113,969		113,969			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,338,941	390,870	1,785,321	3,515,132		3,515,132	(622,869)	2,892,263			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	(3,796)	21		13
14	Non-Care Related Interest	(40,931)	27		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,010)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(125,122)	27		18
19	Entertainment				19
20	Contributions	(2,175)	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	(8,505)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,698)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (185,237)		\$	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)	(437,632)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (437,632)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (622,869)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Columbus Manor Residential Care Home# 0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,698)	0	0	0	0	0	0	0	0	0	0	(2,698)	20
21	Clerical & General Office Expenses	(3,796)	0	0	0	0	0	0	0	0	0	0	(3,796)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(2,010)	0	0	0	0	0	0	0	0	0	0	(2,010)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(168,228)	0	0	0	0	0	0	0	0	0	0	(168,228)	27
28	TOTAL General Administration	(176,732)	0	0	0	0	0	0	0	0	0	0	(176,732)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(176,732)	0	0	0	0	0	0	0	0	0	0	(176,732)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	13,333	0	0	0	0	0	0	0	0	0	13,333	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	29,035	0	0	0	0	0	0	0	0	0	29,035	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(480,000)	0	0	0	0	0	0	0	0	0	(480,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(8,505)	0	0	0	0	0	0	0	0	0	0	(8,505)	36
37	TOTAL Ownership	(8,505)	(437,632)	0	0	0	0	0	0	0	0	0	(446,137)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(185,237)	(437,632)	0	0	0	0	0	0	0	0	0	(622,869)	45

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%	16,910	16,910	3
4	V	32	Loan Expense		CM LLC	0.00%	12,125	12,125	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			\$ 42,368	\$ * (437,632)	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

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

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

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	\$ 50,000	varies	0.0262	\$ 40,931	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 314,438	\$ 50,000			\$ 40,931	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	\$ 50,000			\$ 40,931	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 2011 report.			\$	273,998	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.)			\$	184,041	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(89,957)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	268,336	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.			\$	178,379	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	153,168	8	
		2008	148,043	9	
		2009	172,407	10	
		2010	179,913	11	
		2011	179,165	12	
2nd Installment 2010= 85088.97		13	FOR BHF USE ONLY		
1st Installment 2011= 98952.18		14	FROM R. E. TAX STATEMENT FOR 2011 \$		13
		15	PLUS APPEAL COST FROM LINE 5 \$		14
		16	LESS REFUND FROM LINE 6 \$		15
		17	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Columbus Manor Residential Care Home 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 2011 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 2011.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 16-16-222-019-0000	5107 W Jackson Blvd	\$ 179,164.78	\$ 179,164.78
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 179,164.78	\$ 179,164.78

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

A. Square Feet: 41,308

B. General Construction Type: Exterior BrickFrame Fire ResistantNumber of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

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		20			3,543	46
47	Electrical	1990	2,202		20			2,202	47
48	Exit Doors	1991	19,211		20			19,211	48
49	Doors, etc	1991	14,655		20			14,655	49
50	Electrical	1991	3,507		20			3,507	50
51	New Door	1992	1,330	27	20	27		1,330	51
52	Roof Improvement	1992	8,950	217	20	217		8,950	52
53	Windows	1992	3,150	72	20	72		3,150	53
54	Exit/Interior Doors	1993	6,100	305	20	305		5,644	54
55	Remodel Nurse's Station	1994	16,000	800	20	800		15,200	55
56	Outside Door	1994	2,882	144	20	144		2,737	56
57	Remodel Nurse's Station	1994	20,300	1,015	20	1,015		19,285	57
58	Roof Replacement	1995	28,751	1,438	20	1,438		25,882	58
59	Remodel Nurse's Station	1995	17,710	886	20	886		15,946	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		3,430	63
64	Storm Windows	1999	6,059	303	20	303		4,242	64
65	Wall Repair	1999	3,098	155	20	155		2,170	65
66	AC Prep	1999	1,824	92	20	92		1,288	66
67	New Fans	1999	1,932	97	20	97		1,358	67
68	AC Prep	1999	2,168	109	20	109		1,526	68
69	Exhaust Fans	1999	9,450	473	20	473		6,622	69
70	TOTAL (lines 4 thru 69)		\$ 1,468,478	\$ 6,378		\$ 6,378	\$	\$ 1,452,634	70

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

Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

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	\$ 6,378		\$ 6,378	\$	\$ 1,452,634	1
2	<u>Radiator</u>	2000	10,900	545	20	545		7,085	2
3	<u>PTAK Unit</u>	2000	8,606	431	20	431		5,595	3
4	<u>Four Baseboard Heaters</u>	2001	1,778	89	20	89		1,024	4
5	<u>Nursing Department Cabinets</u>	2006	5,948	298	20	298		3,212	5
6	<u>Front Sign</u>	2007	6,889	460	15	460		2,530	6
7	<u>New Doors</u>	2007	13,676	912	15	912		5,016	7
8	<u>Plumbing Upgrades</u>	2007	8,580	572	15	572		2,873	8
9	<u>New Patio</u>	2007	2,200	147	15	147		809	9
10	<u>Heating Improvements</u>	2007	4,400	294	15	294		1,617	10
11	<u>Courtyard Improvements</u>	2007	9,328	622	15	622		3,421	11
12	<u>11 New Windows</u>	2008	8,371	419	20	419		1,885	12
13	<u>38 New Windows</u>	2008	30,400	1,520	20	1,520		6,840	13
14	<u>New Doors</u>	2008	786	40	20	40		180	14
15	<u>Door Closers</u>	2008	2,549	128	20	128		576	15
16	<u>Fire Alarm Replacement</u>	2008	99,423	4,972	20	4,972		22,374	16
17	<u>Emergency Lighting</u>	2008	20,000	1,000	20	1,000		4,500	17
18	<u>3 Sprinkler Heads</u>	2009	1,890	126	15	126		441	18
19	<u>Roof Repairs</u>	2009	3,500	234	15	234		819	19
20	<u>Basement Drywall Repair & Painting</u>	2009	4,145	276	15	276		966	20
21	<u>Tile Floor</u>	2009	2,900	194	15	194		679	21
22	<u>2 Exterior Doors</u>	2009	4,629	309	15	309		1,082	22
23	<u>2 Exterior Doors</u>	2009	4,017	268	15	268		938	23
24	<u>4 New Windows</u>	2009	1,756	117	15	117		410	24
25	<u>Fire Alarm Improvements</u>	2009	5,939	396	15	396		1,386	25
26	<u>Dining Room Security Door</u>	2009	3,180	212	15	212		742	26
27	<u>Replace Subflooring & Tile in 3 Bathrooms</u>	2010	9,176	459	20	459		919	27
28	<u>Replace Subflooring & Tile in 1 Bathroom</u>	2010	1,948	97	20	97		195	28
29	<u>18 Window Screens</u>	2010	526	53	10	53		105	29
30	<u>Public Phone Privacy Wall</u>	2010	742	37	20	37		75	30
31	<u>AC Installation</u>	2010	3,430	171	20	171		513	31
32	<u>Five new doors installed</u>	2011	4,455	446	10	446		669	32
33	<u>Five fire rated doors installed</u>	2011	6,700	670	10	670		1,005	33
34	TOTAL (lines 1 thru 33)		\$ 1,761,245	\$ 22,892		\$ 22,892	\$	\$ 1,533,115	34

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

Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

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	\$ 22,892		\$ 22,892	\$	\$ 1,533,115	1
2 Replace Sprinkler Heads	2012	6,382	213	15	213		213	2
3 8 Fire Doors, Escape Window Well	2012	14,635	488	15	488		488	3
4 New Electric Data Entry for Alarm System	2012	7,112	237	15	237		237	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)		\$ 1,789,374	\$ 23,830		\$ 23,830	\$	\$ 1,534,053	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	\$373,067	\$22,836	\$22,836	\$	5/30	\$283,239	71
72	Current Year Purchases	7,256	428	428		5/10	428	72
73	Fully Depreciated Assets	1,196,033				5/30	1,196,033	73
74								74
75	TOTALS	\$1,576,356	\$23,264	\$23,264	\$		\$1,479,700	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 B usiness	Ford Fusion 2008	2007	\$33,307	\$3,328	\$3,328	\$	5	\$33,307	76
77	Facility B usiness	Ford Fusion 2012	2012	28,248	2,825	2,825		5	2,825	77
78										78
79										79
80	TOTALS			\$61,555	\$6,153	\$6,153	\$		\$36,132	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)	\$3,461,285	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$53,247	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$53,247	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)	\$3,049,885	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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 41,593	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	107,245		3
4	Supply Inventory (priced at)	1,800		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 150,638	\$	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	1,057,032		15
16	Equipment, at Historical Cost	741,388		16
17	Accumulated Depreciation (book methods)	(1,364,925)		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)	\$ 433,495	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 584,133	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ (21,082)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	261,799		29
30	Accrued Salaries Payable	26,532		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,123		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)	\$ 455,371	\$	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)	\$ 455,371	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 128,762	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 584,133	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,225,475	1
2	Restatements (describe):		2
3	Prior Year Adjustment to Exchange Account	(96,219)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,129,256	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,155,833)	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	(844,660)	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)	\$ (2,000,493)	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)	\$ 128,762	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Columbus Manor Residential Care Home

0007781

Report Period Beginning: 1/1/12

Ending:

12/31/12

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,337,923	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,337,923	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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21,375	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,375	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)	\$ 2,359,299	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	964,026	31
32	Health Care	986,473	32
33	General Administration	678,767	33
	B. Capital Expense		
34	Ownership	771,897	34
	C. Ancillary Expense		
35	Special Cost Centers	113,969	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)*	\$ 3,515,132	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,155,833)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,155,833)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* 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
2	Assistant Director of Nursing					2
3	Registered Nurses	2,468	2,628	101,915	38.78	3
4	Licensed Practical Nurses	14,536	15,540	354,672	22.82	4
5	CNAs & Orderlies	32,188	34,784	317,398	9.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,900	4,204	50,159	11.93	10
11	Social Service Workers	5,422	5,950	100,854	16.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,035	14,279	180,758	12.66	15
16	Dishwashers					16
17	Maintenance Workers	3,840	4,088	68,116	16.66	17
18	Housekeepers	7,539	8,267	78,612	9.51	18
19	Laundry	3,695	4,143	36,558	8.82	19
20	Administrator	2,024	2,080		0.00	20
21	Assistant Administrator	1,991	2,071	46,898	22.65	21
22	Other Administrative					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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,638	98,034	\$ 1,335,940 *	\$ 13.63	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		\$ 9,504		35
36	Medical Director				36
37	Medical Records Consultant		7,640		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		735		44
45	Social Service Consultant		1,331		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,210		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.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Columbus Manor Residential Care Home

0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patrick J O'Brien	Administrator	50	\$ 0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
Bosworth Law Office	Legal	\$ 3,813
Caitlin Deductible Rec. Group	Legal(no copies)	5,000
Polsinelli, Shugart	Legal	58,976
Zoller Swanson & Co.	Accounting	29,820
Canon Fire Protection	Fire	4,072
Illinois Fire and Safety	Fire	626
MDI Archive	Computer	3,109
Caitlin Deductible Rec. Group	Legal	1,766
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 107,182

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 80,178
Unemployment Compensation Insurance	37,714
FICA Taxes	102,479
Employee Health Insurance	4,775
Employee Meals	24,304
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Department of Revenue - Head Tax	(364)
TOTAL (agree to Schedule V, line 22, col.8)	\$ 249,086

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,990
Advertising: Employee Recruitment	0
Health Care Worker Background Check (Indicate # of checks performed 105)	1,050
Patient Background Checks 7	1,165
Yellow Page Advertising	2,502
Secretary of State Annual Report	100
Costco Memb=110, prior year bal=2290	2,400
MES of Illinois	175
Cablelascom Direct Marketing	196
Less: Public Relations Expense (	
Non-allowable advertising	(196)
Yellow page advertising	(2,502)
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,880

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
Michigan Peer Review	2,105
Real Estate License Course	135
Entertainment Expense (	
TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,240

* Attach copy of IMRF notifications

**See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

