

		FOR OHF USE				

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0037556</u></p> <p><b>Facility Name:</b> <u>Columbia Convalescent Center</u></p> <p><b>Address:</b> <u>253 Bradington Dr.</u> <u>Columbia</u> <u>62236</u>          Number City Zip Code</p> <p><b>County:</b> <u>Monroe</u></p> <p><b>Telephone Number:</b> <u>(618) 281-6800</u> Fax # <u>(618) 281-6557</u></p> <p><b>IDPA ID Number:</b> <u>37-1280633001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>12/19/91</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>J. Wayne Franklin</u> <b>Telephone Number:</b> <u>(618) 624-2157</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/00</u> to <u>12/31/00</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>David Wendler</u></td> </tr> <tr> <td></td> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) <u>See Accountants Compilation Report</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>J. Wayne Franklin, Senior Manager</u></td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) <u>Blue &amp; Company, LLC</u> <u>125 Springfield Court, Suite #1, O'Fallon, IL 62269</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(618) 624-2157</u> Fax # <u>(618) 624-2159</u></td> </tr> </table> <p align="center"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) <u>David Wendler</u>		(Title) <u>Administrator</u>	<b>Paid Preparer</b>	(Signed) <u>See Accountants Compilation Report</u> (Date) _____		(Print Name and Title) <u>J. Wayne Franklin, Senior Manager</u>		(Firm Name & Address) <u>Blue &amp; Company, LLC</u> <u>125 Springfield Court, Suite #1, O'Fallon, IL 62269</u>		(Telephone) <u>(618) 624-2157</u> Fax # <u>(618) 624-2159</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbia Convalescent Center

# 0037556 Report Period Beginning: 1/1/00 Ending: 12/31/00

**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	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,894</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,894</u>	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	Private Pay	4 Other		
8	SNF	<u>1,389</u>	<u>3,796</u>	<u>2,715</u>	<u>7,900</u>	8
9	SNF/PED					9
10	ICF	<u>13,968</u>	<u>16,932</u>		<u>30,900</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,357</u>	<u>20,728</u>	<u>2,715</u>	<u>38,800</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.26%

D. How many bed-hold days during this year were paid by Public Aid? 219 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 12/31/91

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 12/31/91 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 12 and days of care provided 2,715

Medicare Intermediary Administar Federal

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/99 Fiscal Year: 12/31/99

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

STATE OF ILLINOIS

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1/1/00 Ending: 12/31/00

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	183,286	12,138	10,073	205,497		205,497		205,497		1
2	Food Purchase		162,861		162,861		162,861	(5,134)	157,727		2
3	Housekeeping	135,652	18,948	1,057	155,657		155,657		155,657		3
4	Laundry	53,835	7,886	15,266	76,987		76,987		76,987		4
5	Heat and Other Utilities			129,030	129,030		129,030		129,030		5
6	Maintenance	53,036	23	43,370	96,429		96,429		96,429		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>425,809</b>	<b>201,856</b>	<b>198,796</b>	<b>826,461</b>		<b>826,461</b>	<b>(5,134)</b>	<b>821,327</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,464,158	90,093	9,760	1,564,011	(80,326)	1,483,685		1,483,685		10
10a	Therapy	39,215	78	198,886	238,179	(71,375)	166,804		166,804		10a
11	Activities	60,586	8,346	7	68,939		68,939	(4,800)	64,139		11
12	Social Services	44,122	192	1,373	45,687		45,687		45,687		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,608,081</b>	<b>98,709</b>	<b>219,026</b>	<b>1,925,816</b>	<b>(151,701)</b>	<b>1,774,115</b>	<b>(4,800)</b>	<b>1,769,315</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	78,177		302,284	380,461		380,461		380,461		17
18	Directors Fees										18
19	Professional Services			30,435	30,435		30,435		30,435		19
20	Dues, Fees, Subscriptions & Promotions			27,056	27,056		27,056	(6,389)	20,667		20
21	Clerical & General Office Expenses	128,286	7,322	30,980	166,588		166,588	(582)	166,006		21
22	Employee Benefits & Payroll Taxes			302,750	302,750		302,750		302,750		22
23	Inservice Training & Education			587	587		587		587		23
24	Travel and Seminar			4,416	4,416		4,416		4,416		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			51,948	51,948		51,948		51,948		26
27	Other (specify):*			13,913	13,913		13,913	(13,913)			27
28	<b>TOTAL General Administration</b>	<b>206,463</b>	<b>7,322</b>	<b>764,369</b>	<b>978,154</b>		<b>978,154</b>	<b>(20,884)</b>	<b>957,270</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,240,353</b>	<b>307,887</b>	<b>1,182,191</b>	<b>3,730,431</b>	<b>(151,701)</b>	<b>3,578,730</b>	<b>(30,818)</b>	<b>3,547,912</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			201,170	201,170		201,170	(3,890)	197,280			30
31	Amortization of Pre-Op. & Org.			2,760	2,760		2,760		2,760			31
32	Interest			258,382	258,382		258,382	(5,644)	252,738			32
33	Real Estate Taxes			90,661	90,661		90,661		90,661			33
34	Rent-Facility & Grounds			780	780		780		780			34
35	Rent-Equipment & Vehicles			5,916	5,916		5,916		5,916			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			559,669	559,669		559,669	(9,534)	550,135			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			5,434	5,434	151,701	157,135		157,135			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			6,923	6,923		6,923		6,923			41
42	Provider Participation Fee			62,136	62,136		62,136		62,136			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			74,493	74,493	151,701	226,194		226,194			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,240,353	307,887	1,816,353	4,364,593		4,364,593	(40,352)	4,324,241			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Columbia Convalescent Center**

# **0037556**

Report Period Beginning: **1/1/00**

Ending: **12/31/00**

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,134)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,981)	27		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,890)	30		9
10	Interest and Other Investment Income	(5,644)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,628)	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	(6,264)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,304)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,507)	Var		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (40,352)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (40,352)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39	Medical Supplies	X		10,469	10-3	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	X		69,857	10-3	43
44	Exceptional Care Program					44
45	Other-Attach Schedule <u>PT/OT/ST</u>	X		71,375	10-3	45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 151,701		47

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0037556  
Report Period Beginning: 1/1/00  
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
			Reference
1	Barber & Beauty Income	\$ (4,800)	11
2	Miscellaneous Income	(582)	21
3	Chamber Dues	(125)	20
4			4
5			5
6			6
7			7
8			8
9			9
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89			89
90	<b>Total</b>	(5,507)	90

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Columbia Convalescent Center

# 0037556

Report Period Beginning:

1/1/00

Ending:

12/31/00

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,134)	0	0	0	0	0	0	0	0	0	0	(5,134)	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	<b>TOTAL General Services</b>	<b>(5,134)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(5,134)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	(4,800)	0	0	0	0	0	0	0	0	0	0	(4,800)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	<b>TOTAL Health Care and Programs</b>	<b>(4,800)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,800)</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(6,389)	0	0	0	0	0	0	0	0	0	0	(6,389)	20
21	Clerical & General Office Expenses	(582)	0	0	0	0	0	0	0	0	0	0	(582)	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	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(13,913)	0	0	0	0	0	0	0	0	0	0	(13,913)	27
28	<b>TOTAL General Administration</b>	<b>(20,884)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(20,884)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(30,818)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(30,818)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Columbia Convalescent Center# 0037556 Report Period Beginning:

1/1/00 Ending:

12/31/00

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(3,890)	0	0	0	0	0	0	0	0	0	0	(3,890) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(5,644)	0	0	0	0	0	0	0	0	0	0	(5,644) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(9,534)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,534) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(40,352)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(40,352) 45</b>

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Wolf	50.00%	Eldercare of Alton/Calvin Johnson Care Center	Alton/Belleville	Eldercare, Inc.	Belleville	Nurs. Home Mgmt
Michael Riley	16.00%	Collinsville Care Ctr./Four Fountains Conv. Ctr.	Collinsville/Belleville	SAMAS Partnership	Belleville	Nurs. Home Mgmt
Steve Brant	4.00%	Collinsville Care Ctr./Four Fountains Conv. Ctr.	Collinsville/Belleville			
Minority Shareholders	30.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	Not Applicable	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number      Columbia Convalescent Center      #      0037556      Report Period Beginning:      1/1/00      Ending:      12/31/00

## 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	Steve Wolf	President	Owner	50.00	169,465	10	14.00	Mgmt Fees	\$ 171,772	17	1
2	Michael Riley	Secretary	Owner	16.00	66,366	20	30.00	Mgmt Fees	45,032	17	2
3	Steven Brant	Treasurer	Owner	4.00	67,459	10	17.00	Mgmt Fees	78,180	17	3
4	JoAnne Brant	Accountant	Administrative	0.00	5,181	As Needed		Prof. Fees	850	19-3 & 17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 295,834		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	Not Applicable								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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 1/1/00 Ending: 12/31/00

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		<b>A. Directly Facility Related</b>																	
		<b>Long-Term</b>																	
1		Union Planters		X	Mortgage	\$21,665.39	01/01/94	\$ 2,740,484	\$ 2,222,233	06/05/04	0.0725	\$ 166,914	1						
2		Union Planters		X	Mortgage	\$7,518.65	02/06/98	925,720	888,529	01/06/04	0.0750	66,566	2						
3		Union Planters		X	Mortgage	\$2,095.92	03/06/00	300,000	286,205	12/06/03	0.0825	24,302	3						
4													4						
5													5						
		<b>Working Capital</b>																	
6				X	Vendors						Varies	600	6						
7													7						
8													8						
9		<b>TOTAL Facility Related</b>				\$31,279.96		\$ 3,966,204	\$ 3,396,966			\$ 258,382	9						
		<b>B. Non-Facility Related*</b>																	
10					Interest Income							(5,644)	10						
11													11						
12													12						
13													13						
14		<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (5,644)	14						
15		<b>TOTALS (line 9+line14)</b>						\$ 3,966,204	\$ 3,396,966			\$ 252,738	15						

\* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbia Convalescent Center# 0037556 Report Period Beginning: 1/1/00 Ending: 12/31/00

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	<u>65,350</u>	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.)	\$	<u>78,005</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>12,655</u>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>78,006</u>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<u>90,661</u>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	<u>49,518</u>	8
	1996	<u>46,536</u>	9
	1997	<u>54,206</u>	10
	1998	<u>65,350</u>	11
	1999	<u>78,005</u>	12
	<b>FOR OFF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

## NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbia Convalescent Center# 0037556 Report Period Beginning:1/1/00 Ending:12/31/00

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,079 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories OneC. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

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

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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: 98,579 2. Number of Years Over Which it is Being Amortized: 353. Current Period Amortization: 2,760 4. Dates Incurred: 1991

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	Resident Care	189,566	1991	\$ 249,469	1
2	Resident Care	21,364	1993	28,115	2
3	TOTALS	210,930		\$ 277,584	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbia Convalescent Center# 0037556

Report Period Beginning:

1/1/00

Ending:

12/31/00

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1991	1991	\$ 2,115,587	\$ 52,890	40	\$ 52,890		\$ 480,417	4
5			1991	1991	48,503	3,234	40	1,214	(2,020)	11,027	5
6	10		1998	1998	1,170,228	29,256	40	29,256		70,702	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Land Improvements		1991		147,905	7,395	20	7,395		67,171	9
10	Fixed Equipment		1991		24,679	1,645	18	1,371	(274)	12,689	10
11	Alarm System		1992		910	61	15	61		518	11
12	Water Softner		1992		8,625	575	12	719	144	5,966	12
13	Carpet		1993		1,430	72	12	119	47	893	13
14	Guttering		1994		899	128	8	112	(16)	728	14
15	Pavilion		1994		7,400	617	12	617		4,008	15
16	Miscellaneous Improvements		1995		2,165	309	10	217	(92)	1,190	16
17	Drainage System		1995		1,374	92	15	92		383	17
18	Cold Water Line		1996		6,803	174	39	174		812	18
19	A/C Compressor		1996		1,574	225	7	225		937	19
20	Carpet		1996		591	84	7	84		350	20
21	Hot Water Heater		1996		3,473	496	7	496		2,067	21
22	Heat Trace on Hot Water Pipes		1996		1,535	102	10	154	52	556	22
23	Furnance and Air Conditioner Renovation		1997		1,690	169	10	169		606	23
24	Dayroom Carpet & Window Treatment		1997		7,658	1,094	10	766	(328)	2,939	24
25	Telephone/Voice Mail System		1997		14,738	2,948	10	1,474	(1,474)	5,405	25
26	Entry Area Carpeting		1997		1,080	154	10	108	(46)	375	26
27	UPS Battery Backup System		1997		733	147	10	73	(74)	256	27
28	Door		1997		1,485	38	10	149	111	453	28
29	Fan		1997		1,083	28	10	108	80	329	29
30	Landscaping		1998		4,030	269	15	269		579	30
31	Landscaping		1998		7,429	495	15	495		1,196	31
32	Irrigation System		1998		12,990	866	15	866		2,093	32
33	Parking Lot		1998		15,912	1,061	15	1,061		2,564	33
34	Landscaping		1998		10,479	699	15	699		1,689	34
35	Sidewalks		1998		19,864	1,324	15	1,324		3,200	35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 3,642,852	\$ 106,647		\$ 102,757	\$ (3,890)	\$ 682,098	36

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Columbia Convalescent Center

# 0037556

Report Period Beginning:

1/1/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Bed* <sup>s</sup>	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Draperies & Window Treatments	1998		18,417	3,683	5	3,683		8,905	9
10	Flooring & Carpeting	1998		36,840	3,684	10	3,684		8,739	10
11	Decorating, Wallpaper, Painting	1998		49,156	9,773	5	9,773		23,321	11
12	Alarm, Security System	1998		17,574	2,849	5-7	2,849		5,956	12
13	Attic Ventilating Fans	1998		6,179	618	10	618		1,648	13
14	Storeroom Locks	1998		593	85	7	85		177	14
15	Telephone Equipment	1998		1,940	194	10	194		501	15
16	Light Fixtures	1998		4,291	429	10	429		1,037	16
17	Therapy Room Sink	1998		1,213	173	7	173		360	17
18	Signage	1998		116	12	10	12		29	18
19	Site Lighting	1998		5,684	812	7	812		1,962	19
20	Landscaping	1999		6,955	464	15	464		646	20
21	Water Heater Replacement	1999		35,258	3,526	10	3,526		5,410	21
22	Washer & Dryer	1999		4,600	460	10	460		498	22
23	Air Conditioner	1999		8,965	897	10	897		1,176	23
24	Room Renovations	1999		6,778	929	5-10	929		1,575	24
25	Door Security System	1999		14,347	1,435	10	1,435		2,011	25
26	Landscaping	2000		1,987	47	15	47		47	26
27	Water Heater Replacement	2000		6,848	628	10	628		628	27
28	Carpeting	2000		1,579	79	10	79		79	28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	<b>TOTAL (lines 4 thru 35)</b>			\$ 229,320	\$ 30,777		\$ 30,777	\$	\$ 64,705	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 ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 521,971	\$ 59,716	\$ 59,716	\$		\$ 349,301	37
38	Current Year Purchases	62,341	4,030	4,030			4,030	38
39	Fully Depreciated Assets	38,017					38,017	39
40								40
41	TOTALS	\$ 622,329	\$ 63,746	\$ 63,746	\$		\$ 391,348	41

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Care	1994 Ford Van	1993	\$ 38,214	\$	\$	\$		\$ 38,214	42
43										43
44										44
45										45
46	TOTALS			\$ 38,214	\$	\$	\$		\$ 38,214	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 4,810,299	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 201,170	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 197,280	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (3,890)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,176,365	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbia Convalescent Center

# 0037556

Report Period Beginning: 1/1/00

Ending: 12/31/00

**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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		N/A		\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

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.       /2001       \$ \_\_\_\_\_  
13.       /2002       \$ \_\_\_\_\_  
14.       /2003       \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34.       N/A      

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			N/A		19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	517	\$ 26,783	\$	517	\$ 26,783	1
2	Licensed Speech and Language Development Therapist		hrs		187	12,562		187	12,562	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		385	32,030		385	32,030	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				69,857		69,857	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Lab, X-Ray, Ambulance Other (specify): <b>Medical Supplies</b>					5,434	10,469		5,434 10,469	13
14	<b>TOTAL</b>			\$	1,089	\$ 76,809	\$ 80,326	1,089	\$ 157,135	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Columbia Convalescent Center

# 0037556

Report Period Beginning: 1/1/00

Ending:

12/31/00

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 88,609	\$	1
2	Cash-Patient Deposits	8,483		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	473,330		3
4	Supply Inventory (priced at Cost )	18,710		4
5	Short-Term Investments			5
6	Prepaid Insurance	51,101		6
7	Other Prepaid Expenses	1,767		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 642,000	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	277,584		13
14	Buildings, at Historical Cost	3,292,618		14
15	Leasehold Improvements, at Historical Cost	579,553		15
16	Equipment, at Historical Cost	660,543		16
17	Accumulated Depreciation (book methods)	(1,269,403)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	98,579		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(64,628)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,574,846	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,216,846	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 84,781	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,483		28
29	Short-Term Notes Payable	135,573		29
30	Accrued Salaries Payable	81,319		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,788		31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,005		32
33	Accrued Interest Payable	21,591		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	Other Accruals	39,220		36
37	Accrued Owners Comp	27,000		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 479,760	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	3,250,554		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,250,554	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,730,314	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 486,532	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,216,846	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>415,980</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>415,980</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	570,552	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(500,000)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>70,552</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>486,532</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,561,062	1
2	Discounts and Allowances for all Levels	(193,523)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,367,539	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	355,109	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 355,109	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,800	13
14	Non-Patient Meals	5,134	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	150,217	17
18	Sale of Supplies to Non-Patients	20,937	18
19	Laboratory	10,567	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 191,655	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5,644	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,644	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Vending	10,820	28
28a	Miscellaneous	4,378	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 15,198	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,935,145	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	826,461	31
32	Health Care	1,925,816	32
33	General Administration	978,154	33
<b>B. Capital Expense</b>			
34	Ownership	559,669	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	12,357	35
36	Provider Participation Fee	62,136	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,364,593	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	570,552	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 570,552	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Columbia Convalescent Center**

# **0037556**

Report Period Beginning: **1/1/00**

Ending:

**12/31/00**

**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	1,934	2,129	\$ 71,967	\$ 33.80	1
2	Assistant Director of Nursing	2,040	2,205	49,408	22.41	2
3	Registered Nurses	13,137	14,113	224,299	15.89	3
4	Licensed Practical Nurses	15,895	17,057	285,434	16.73	4
5	Nurse Aides & Orderlies	75,767	81,400	833,049	10.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,546	6,926	60,586	8.75	9
10	Activity Assistants					10
11	Social Service Workers	3,013	3,332	44,122	13.24	11
12	Dietician					12
13	Food Service Supervisor	2,551	2,796	25,034	8.95	13
14	Head Cook	6,287	6,773	66,952	9.89	14
15	Cook Helpers/Assistants					15
16	Dishwashers	10,536	11,262	91,300	8.11	16
17	Maintenance Workers	5,131	5,435	53,036	9.76	17
18	Housekeepers	16,216	17,188	135,652	7.89	18
19	Laundry	5,212	5,603	53,835	9.61	19
20	Administrator	1,967	2,250	78,177	34.75	20
21	Assistant Administrator					21
22	Other Administrative	3,772	4,139	63,883	15.43	22
23	Office Manager	7,042	7,568	64,402	8.51	23
24	Clerical					24
25	Vocational Instruction	4,485	4,790	39,215	8.19	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)	181,531	194,966	\$ 2,240,351 *	\$ 11.49	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	143	\$ 7,170	1-3	35
36	Medical Director	120	9,000	9-3	36
37	Medical Records Consultant	36	900	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	29	720	10-3	39
40	Physical Therapy Consultant	2,015	98,178	10-3	40
41	Occupational Therapy Consultant	1,846	88,062	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	187	12,646	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	39	1,350	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,415	\$ 218,026		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT



**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										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	
1	Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

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? Yes  
If YES, give association name and amount. Illinois Health Care Assoc. \$4,357
- (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? N/A
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line 10-3
- (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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 62,136  
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 of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,134
- (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. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0%  
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? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT