

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0037556

Facility Name: Columbia Convalescent Center

Address: 253 Bradington Drive Columbia 62236
 Number City Zip Code

County: Monroe

Telephone Number: 618-281-6800 **Fax #** 618-281-6557

HFS ID Number: 37-1280633001

Date of Initial License for Current Owners: 11/01/1991

Type of Ownership:

<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 _____	

In the event there are further questions about this report, please contact:
Name: David Wendler **Telephone Number:** 618-281-6800

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2006 to 12/31/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Steven C. Wolf</u>	
	(Title) <u>Owner</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

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 Columbia Convalescent Center# 0037556 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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>75</u>	Skilled (SNF)	<u>75</u>	<u>27,375</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>44</u>	Intermediate (ICF)	<u>44</u>	<u>16,060</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>119</u>	TOTALS	<u>119</u>	<u>43,435</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF		<u>1,581</u>	<u>1,996</u>	<u>3,577</u>	8
9	SNF/PED					9
10	ICF	<u>20,250</u>	<u>15,387</u>		<u>35,637</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,250</u>	<u>16,968</u>	<u>1,996</u>	<u>39,214</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.28%

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

0 (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)

NoneF. 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 11/1/1991

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ 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 1,996Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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
	A. General Services										
1	Dietary	225,178	13,370	7,151	245,699		245,699	245,699			1
2	Food Purchase		187,999		187,999		187,999	187,999			2
3	Housekeeping	191,341	16,448		207,789		207,789	207,789			3
4	Laundry	74,937	15,842	1,920	92,699		92,699	92,699			4
5	Heat and Other Utilities			146,840	146,840		146,840	146,840			5
6	Maintenance	56,505	22,098	47,326	125,929		125,929	125,929			6
7	Other (specify):*										7
8	TOTAL General Services	547,961	255,757	203,237	1,006,955		1,006,955	1,006,955			8
	B. Health Care and Programs										
9	Medical Director			10,050	10,050		10,050	10,050			9
10	Nursing and Medical Records	1,942,946	42,281	26,596	2,011,823	16,824	2,028,647	2,028,647			10
10a	Therapy			214,381	214,381	(16,824)	197,557	197,557			10a
11	Activities	87,737	9,041		96,778		96,778	96,778			11
12	Social Services	56,916	159	2,825	59,900		59,900	59,900			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,087,599	51,481	253,852	2,392,932		2,392,932	2,392,932			16
	C. General Administration										
17	Administrative	94,561		198,919	293,480	(430)	293,050	293,050			17
18	Directors Fees										18
19	Professional Services			21,862	21,862	330	22,192	22,192			19
20	Dues, Fees, Subscriptions & Promotions			17,599	17,599		17,599	(5,199)	12,400		20
21	Clerical & General Office Expenses	133,299		58,747	192,046	100	192,146	192,146			21
22	Employee Benefits & Payroll Taxes			562,771	562,771		562,771	562,771			22
23	Inservice Training & Education										23
24	Travel and Seminar			2,884	2,884		2,884	2,884			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			157,622	157,622		157,622	(23,452)	134,170		26
27	Other (specify):* cable TV, contrib			8,699	8,699		8,699	(8,699)			27
28	TOTAL General Administration	227,860		1,029,103	1,256,963		1,256,963	(37,350)	1,219,613		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,863,420	307,238	1,486,192	4,656,850		4,656,850	(37,350)	4,619,500		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Columbia Convalescent Center #0037556 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			162,867	162,867		162,867		162,867		30
31	Amortization of Pre-Op. & Org.			2,760	2,760		2,760		2,760		31
32	Interest			167,547	167,547		167,547	(1,483)	166,064		32
33	Real Estate Taxes			68,130	68,130		68,130		68,130		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			12,479	12,479		12,479		12,479		35
36	Other (specify):*										36
37	TOTAL Ownership			413,783	413,783		413,783	(1,483)	412,300		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		48,905	4,735	53,640		53,640		53,640		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops		4,961		4,961		4,961		4,961		41
42	Provider Participation Fee			65,152	65,152		65,152		65,152		42
43	Other (specify):*			5,392	5,392		5,392		5,392		43
44	TOTAL Special Cost Centers		53,866	75,279	129,145		129,145		129,145		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,863,420	361,104	1,975,254	5,199,778		5,199,778	(38,833)	5,160,945		45

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

Facility Name & ID Number Columbia Convalescent Center

0037556

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,774)	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				9
10	Interest and Other Investment Income	(1,483)	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	(40)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,925)	27		20
21	Owner or Key-Man Insurance	(23,452)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,159)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (38,833)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (38,833)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Columbia Convalescent Center

ID# 0037556

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Columbia Convalescent Center

0037556

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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)	
	A. General Services													
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	(5,199)	0	0	0	0	0	0	0	0	0	0	(5,199)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(23,452)	0	0	0	0	0	0	0	0	0	0	(23,452)	26
27	Other (specify):*	(8,699)	0	0	0	0	0	0	0	0	0	0	(8,699)	27
28	TOTAL General Administration	(37,350)	0	0	0	0	0	0	0	0	0	0	(37,350)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(37,350)	0	0	0	0	0	0	0	0	0	0	(37,350)	29

STATE OF ILLINOIS

Facility Name & ID Number Columbia Convalescent Center

0037556 Report Period Beginning:

01/01/2006 Ending:

Summary B

12/31/2006

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

	Capital Expense	PAGES	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	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,483)	0	0	0	0	0	0	0	0	0	0	(1,483)	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	TOTAL Ownership	(1,483)	0	(1,483)	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)	(38,833)	0	(38,833)	45									

Facility Name & ID Number Columbia Convalescent Center

0037556

Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	Belleville/Alton	Eldercare/SAMAS	Belleville	Mgmt Co.
Michael Riley	16.00%			SAMAS	Belleville	Mgmt Co.
Minority Shareholders	34.00%					

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	17 Management Fees	\$ 198,489	SAMAS PARTNERSHIP	0.00%	\$ 198,489	\$	1
2	V	21 Bank Charges	100	SAMAS PARTNERSHIP	0.00%	100		2
3	V	19 Accounting fees	330	SAMAS PARTNERSHIP		330		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		\$ 198,919			\$ 198,919	\$ *	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: 01/01/2006 Ending: 12/31/2006

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/Admin	50.00	A	10	14.00	Mgmt fees	\$ 106,192	17-3	1
2	Michael Riley	Secretary	Owner/Admin	16.00	0	20	30.00	Mgmt fees	54,360	17-3	2
3	Steven Brant	Treasurer	Owner/Admin	4.00	B	10	17.00	Mgmt fees	37,937	17-3	3
4											4
5											5
6		A- Eldercare, Inc.	169464								6
7											7
8		B- Four Fountains	66467								8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 198,489		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 Columbia Convalescent Center

0037556 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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									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

Facility Name & ID Number

Columbia Convalescent Center

0037556

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$			\$	1						
2												2						
3												3						
4	The Bank of Edwardsville		X	Mortgage	\$20,608.61	12/22/05	2,636,000	2,525,971	08/11/2019	variable	157,331	4						
5												5						
	Working Capital																	
6												6						
7	1st Insurance Funding		X	Insurance package	\$10,305.00	11/6/06	89,734		7/1/07	7.9900	3,052	7						
8	The Bank of Edwardsville		X	Working Capital	interest only	12/15/06	500,000	50,000	12/15/07	variable	7,164	8						
9	TOTAL Facility Related				\$30,913.61		\$ 3,225,734	\$ 2,575,971			\$ 167,547	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (1,483)	14						
15	TOTALS (line 9+line14)						\$ 3,225,734	\$ 2,575,971			\$ 166,064	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line # _____* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ <u>68,130</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>67,625</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>(505)</u>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <u>68,635</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. (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.		\$ <u>68,130</u>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	<u>77,744</u>	8
	2002	<u>77,278</u>	9
	2003	<u>82,368</u>	10
	2004	<u>67,390</u>	11
	2005	<u>67,625</u>	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2005 \$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

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

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Columbia Convalescent Center COUNTY Monroe

FACILITY IDPH LICENSE NUMBER 0037556

CONTACT PERSON REGARDING THIS REPORT David Wendler

TELEPHONE 618-281-6800 FAX #: 618-281-6557

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-17-481-028-000</u>	<u>Lot 2 & Pt Lot 1 Bradington Pl</u>	\$ <u>17,178.00</u>	\$ <u>17,178.00</u>
2. <u>04-17-481-005-000</u>	<u>Part Lot 4 Sur 416</u>	\$ <u>680.00</u>	\$ <u>680.00</u>
3. <u>04-17-481-004-000</u>	<u>Part Lot 4 Sur 416</u>	\$ <u>49,767.00</u>	\$ <u>49,767.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>67,625.00</u>	\$ <u>67,625.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Columbia Convalescent Center

0037556 Report Period Beginning:

01/01/2006 Ending:

12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,079 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	189,566	1991	\$ 249,469	1
2	Resident Care	21,364	1993	28,115	2
3	TOTALS	210,930		\$ 277,584	3

Facility Name & ID Number Columbia Convalescent Center

0037556

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1991	1991	\$ 2,115,587	\$ 52,890	40	\$ 52,890		\$ 846,235	4
5			1991	1991	48,503	2,425	15	2,425		47,695	5
6	20		1998	1998	1,170,228	29,256	40	29,256		246,236	6
7											7
8											8
	Improvement Type**										
9	Land Improvements		1991		147,905	7,176	20	7,176		111,327	9
10	Fixed Equipment		1991		24,679	1,280	15	1,280		24,312	10
11	Alarm System		1992		910	60	15	60		910	11
12	Water Softner		1992		8,625	575	15	575		8,050	12
13	Carpet		1993		1,430		12			1,400	13
14	Guttering		1994		899		7			870	14
15	Pavilion		1994		7,400	308	12	308		7,400	15
16	Misc Improvements		1995		2,165		10			2,121	16
17	Drainage System		1996		1,374	92	15	92		931	17
18	Cold Water Line		1996		6,803	174	39	174		1,861	18
19	A/C Compressor		1996		1,574		7			1,574	19
20	Carpet		1996		591		7			591	20
21	Hot Water Heater		1996		3,473		7			3,473	21
22	Heat Trace & Hot Water Pipes		1996		1,535	102	15	102		1,015	22
23	Furnace and Air conditioning renovation		1997		1,690	169	10	169		1,620	23
24	Day Room Carpet and Window Treatments		1997		7,658		7			7,658	24
25	Telephone/Voice Mail System		1997		14,739		5			14,739	25
26	Entry Area Carpeting		1997		1,080		7			1,080	26
27	UPS Battery Back-up System		1997		733		5			733	27
28	Door		1997		1,485	38	39	38		349	28
29	Fan		1997		1,083	28	39	28		254	29
30	Landscaping		1998		4,030	269	15	269		2,190	30
31	Landscaping		1998		7,429	495	15	495		4,169	31
32	Irrigation System		1998		12,990	866	15	866		7,289	32
33	Parking Lot		1998		15,912	1,061	15	1,061		8,928	33
34	Landscaping		1998		10,479	699	15	699		5,880	34
35	Sidewalks		1998		19,864	1,324	15	1,324		11,146	35
36			1998		18,417		5			18,417	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 Columbia Convalescent Center

0037556

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Flooring & Carpeting	1998	\$ 36,840	\$ 3,684	10	\$ 3,684	\$	\$ 30,971	37
38	Decorating Wallpapering & Painting	1998	49,156		5-10 yr			49,062	38
39	Alarm Security System	1998	17,574	291	5-7yr	291		16,809	39
40	Attic Ventilating Fans	1998	6,179	618	10	618		5,355	40
41	Storeroom Locks	1998	593		7			593	41
42	Telephone Equipment	1998	1,940	194	10	194		1,665	42
43	Light Fixtures	1998	4,291	429	10	429		3,612	43
44	Therapy Room Sink	1998	1,213		7			1,213	44
45	Signage	1998	116	12	10	12		98	45
46	Site Lighting	1998	5,684		7			5,684	46
47	Landscaping	1999	6,955	464	15	464		3,428	47
48	Water Heater Replacement	1999	35,258	3,526	10	3,526		26,565	48
49	Washer & Dryer	1999	4,600	460	10	460		3,258	49
50	Air Conditioner	1999	8,965	897	10	897		6,555	50
51	Room Renovations	1999	6,778	426	5-10y	426		5,677	51
52	Door Security System	1999	14,347	1,435	10	1,435		10,619	52
53	Landscaping	2000	1,987	132	15	132		838	53
54	Water Heater Replacement	2000	6,848	685	10	685		4,737	54
55	Carpeting	2000	1,579	158	10	158		1,026	55
56	Floor Tile	2001	1,546	155	10	155		915	56
57	Landscaping	2001	2,127	142	15	142		796	57
58	Evaporator Coil	2001	2,514	251	10	251		1,404	58
59	Vinal Trim Window	2001	6,459	646	10	646		3,337	59
60	Painting	2001	6,080	608	10	608		3,091	60
61	Telephone System	2001	1,631	299	5	299		1,631	61
62	Alert System	2001	6,443	920	7	920		4,370	62
63	Alert System	2002	6,442	921	7	921		4,373	63
64	Landscaping	2002	417	28	15	28		132	64
65	Heating Cooling	2002	7,477	748	10	748		3,429	65
66	Carpeting, fire doors, electrical	2002	4,968	497	10	497		2,172	66
67	Parking Lot	2003	3,420	228	15	228		703	67
68	Hot Water Heater	2002	2,380	238	10	238		1,170	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,924,076	\$ 118,379		\$ 118,379	\$	\$ 1,595,741	70

**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:

01/01/2006 Ending: 12/31/2006

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,924,076	\$ 118,379		\$ 118,379	\$	\$ 1,595,741	1
2	Bathroom impr	2003	624	62	10	62		203	2
3	Air Conditioning/temp control	2003	3,604	360	10	360		1,171	3
4	Nurse Call System	2003	1,075	107	10	107		340	4
5	Hot water system	2003	5,603	560	10	560		2,054	5
6	Payroll wiring/ time system	2003	2,000	200	10	200		768	6
7	Valves,adapters, coils A/C	2003	3,626	363	10	363		1,325	7
8	Security upgrades	2003	522	52	10	52		187	8
9	Control joints	2003	1,019	102	10	102		374	9
10	Parking lot sealer/stripping	2004	300	38	15	38		58	10
11	Guard rails, concrete work docking area	2004	17,387	1,202	15	1,202		2,374	11
12	New Lighting	2004	21,784	2,178	10	2,178		5,575	12
13	Painting	2004	2,115	211	10	211		508	13
14	Air Conditioning/Hot water system	2004	8,069	807	10	807		2,325	14
15	Wiring call system, security system	2004	2,917	292	10	292		795	15
16	Flooring	2004	1,777	178	10	178		429	16
17	Kitchen Hood, grill	2004	2,871	287	10	287		612	17
18	Fire dampers	2004	2,600	260	10	260		520	18
19	Generator tank	2004	3,632	363	10	363		1,029	19
20	Plumbing	2004	974	97	10	97		276	20
21	Ventilation Laundry dept	2004	15,505	1,551	10	1,551		4,005	21
22	Thermocouplers	2004	1,208	121	10	121		352	22
23	Awnings	2005	2,210	221	10	221		341	23
24	Doors	2005	3,981	398	10	398		697	24
25	Plumbing and filter system	2005	9,949	995	10	995		1,824	25
26	Underground piping	2005	1,885	188	10	188		236	26
27	Handrails	2005	4,518	452	10	452		527	27
28	Landscaping	2005	1,300	87	15	87		101	28
29	Doors and kickplates	2006	1,438	33	10	33		33	29
30	Plumbing,water conditioners, heaters	2006	20,427	1,615	10	1,615		1,615	30
31	Air conditioning	2006	7,979	199	10	199		199	31
32	cubicle curtains	2006	294	17	7	17		17	32
33	sidewalk and landscaping	2006	9,320	103	15	103		103	33
34	TOTAL (lines 1 thru 33)		\$ 4,086,589	\$ 132,078		\$ 132,078	\$	\$ 1,626,714	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 288,518	\$ 29,202	\$ 29,202	\$		\$ 182,447	71
72	Current Year Purchases	26,023	1,762	1,762		5-7 yrs	1,762	72
73	Fully Depreciated Assets	449,458					442,420	73
74								74
75	TOTALS	\$ 763,999	\$ 30,964	\$ 30,964	\$		\$ 626,629	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1994 Ford Van	1993	\$ 38,214	\$	\$	\$	5	\$ 38,214	76
77										77
78										78
79										79
80	TOTALS			\$ 38,214	\$	\$	\$		\$ 38,214	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	5,166,386	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	163,042	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	163,042	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,291,557	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.

Facility Name & ID Number Columbia Convalescent Center

0037556

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 12,480

Description: Office 4673/Nursing 7807

(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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
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.)

	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	10-A-3	hrs	\$	1,287	\$ 84,907	\$ 175	1,287	\$ 85,082	1
2	Licensed Speech and Language Development Therapist	10-A-3	hrs		183	15,627		183	15,627	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-A-3	hrs		1,706	99,418	275	1,706	99,693	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				48,597		48,597	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Lab/X-Ray</u>	39-3				4,735	308		5,043	13
14	TOTAL			\$	3,176	\$ 204,686	\$ 49,355	3,176	\$ 254,041	14

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

Facility Name & ID Number Columbia Convalescent Center# 0037556Report Period Beginning: 01/01/2006

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 41,482	\$	1
2	Cash-Patient Deposits	13,666		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>none</u>)	769,283		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	89,696		6
7	Other Prepaid Expenses	21,830		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 935,957	\$	10
	B. Long-Term Assets			
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	793,970		15
16	Equipment, at Historical Cost	802,234		16
17	Accumulated Depreciation (book methods)	(2,291,557)		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): <u>Unamortized fin fees</u>	17,391		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,892,240	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,828,197	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 246,986	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,666		28
29	Short-Term Notes Payable	167,030		29
30	Accrued Salaries Payable	156,461		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,928		31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,635		32
33	Accrued Interest Payable	6,708		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>401K</u>	1,981		36
37	<u>Accrued management fees</u>	18,919		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 689,314	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,408,941		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)	\$ 2,408,941	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,098,255	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 729,942	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,828,197	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 641,358	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 641,358	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	408,584	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	(320,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 88,584	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)	\$ 729,942	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Columbia Convalescent Center# 0037556Report Period Beginning: 01/01/2006Ending: 12/31/2006**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,157,107	1
2	Discounts and Allowances for all Levels	(81,936)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,075,171	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	393,804	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 393,804	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	7,700	13
14	Non-Patient Meals	4,124	14
15	Telephone, Television and Radio	7,406	15
16	Rental of Facility Space		16
17	Sale of Drugs	80,392	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,216	19
20	Radiology and X-Ray	1,455	20
21	Other Medical Services	13,526	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 128,819	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,483	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,483	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	8,436	28
28a	Misc	649	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,085	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,608,362	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,006,955	31
32	Health Care	2,392,932	32
33	General Administration	1,256,963	33
B. Capital Expense			
34	Ownership	413,783	34
C. Ancillary Expense			
35	Special Cost Centers	63,993	35
36	Provider Participation Fee	65,152	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,199,778	40
41	Income before Income Taxes (line 30 minus line 40)**	408,584	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 408,584	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? n/a If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number Columbia Convalescent Center

0037556

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

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	2,027	2,232	\$ 88,412	\$ 39.61	1
2	Assistant Director of Nursing	1,955	2,178	61,869	28.41	2
3	Registered Nurses	3,453	3,834	97,193	25.35	3
4	Licensed Practical Nurses	26,911	28,947	516,708	17.85	4
5	CNAs & Orderlies	78,791	84,731	1,026,092	12.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,654	5,259	55,961	10.64	8
9	Activity Director					9
10	Activity Assistants	8,354	9,017	87,737	9.73	10
11	Social Service Workers	3,696	4,008	56,916	14.20	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,295	33,109	14.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,323	5,830	67,352	11.55	15
16	Dishwashers	14,386	15,397	124,717	8.10	16
17	Maintenance Workers	3,926	4,226	56,505	13.37	17
18	Housekeepers	20,344	21,868	191,341	8.75	18
19	Laundry	7,994	8,693	74,937	8.62	19
20	Administrator	2,039	2,298	94,561	41.15	20
21	Assistant Administrator					21
22	Other Administrative	3,584	4,061	72,716	17.91	22
23	Office Manager					23
24	Clerical	5,639	6,022	60,583	10.06	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) <u>other nurs admin</u>	3,915	4,227	96,711	22.88	33
34	TOTAL (lines 1 - 33)	199,071	215,123	\$ 2,863,420 *	\$ 13.31	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	99	\$ 4,972	L 1 C 3	35
36	Medical Director	varies	10,050	L 9 C 3	36
37	Medical Records Consultant	17	682	L 10 C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	22	780	L 10 C 3	39
40	Physical Therapy Consultant	165	10,160	L 10 C 3	40
41	Occupational Therapy Consultant	94	6,376	L 10 C 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	287	L 10 C 3	43
44	Activity Consultant				44
45	Social Service Consultant	80	2,825	L 12 C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	481	\$ 36,132		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	40	\$ 1,401	L 10 C 3	50
51	Licensed Practical Nurses	313	9,128	L 10 C 3	51
52	Certified Nurse Assistants/Aides	594	8,084	L 10 C 3	52
53	TOTAL (lines 50 - 52)	947	\$ 18,613		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,152
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? 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? n/a Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.