

		FOR BHF USE				

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 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
<b>IRS Exemption Code</b> _____	<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 01/01/2007 to 12/31/2007 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Steven C. Wolf</u>	
<b>Paid Preparer</b>	(Title) <u>Owner</u>	
	(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: 01/01/2007 Ending: 12/31/2007

## 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 bedsN/A

	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>535</u>	<u>2,607</u>	<u>3,142</u>	8
9	SNF/PED					9
10	ICF	<u>19,449</u>	<u>15,038</u>		<u>34,487</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,449</u>	<u>15,573</u>	<u>2,607</u>	<u>37,629</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 86.63%

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? YesG. 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 2,607Medicare Intermediary National Government Services

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED  
CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	229,878	12,625	7,631	250,134		250,134	(4,006)	246,128		1
2	Food Purchase		180,185		180,185		180,185		180,185		2
3	Housekeeping	191,842	18,607		210,449		210,449		210,449		3
4	Laundry	74,731	16,678	12,064	103,473		103,473		103,473		4
5	Heat and Other Utilities			147,642	147,642		147,642		147,642		5
6	Maintenance	60,603	22,677	47,145	130,425		130,425		130,425		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	557,054	250,772	214,482	1,022,308		1,022,308	(4,006)	1,018,302		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,959,053	48,705	41,627	2,049,385	14,425	2,063,810		2,063,810		10
10a	Therapy			282,155	282,155	(14,425)	267,730		267,730		10a
11	Activities	88,019	10,673		98,692		98,692		98,692		11
12	Social Services	61,177	46	1,317	62,540		62,540		62,540		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,108,249	59,424	335,899	2,503,572		2,503,572		2,503,572		16
	<b>C. General Administration</b>										
17	Administrative	96,832		167,231	264,063		264,063		264,063		17
18	Directors Fees										18
19	Professional Services			31,959	31,959		31,959	375	32,334		19
20	Dues, Fees, Subscriptions & Promotions			23,879	23,879		23,879	(5,928)	17,951		20
21	Clerical & General Office Expenses	141,115	14,106	49,859	205,080		205,080	(202)	204,878		21
22	Employee Benefits & Payroll Taxes			534,212	534,212		534,212		534,212		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,081	3,081		3,081		3,081		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			146,278	146,278		146,278	(23,452)	122,826		26
27	Other (specify):*			8,015	8,015		8,015	(8,015)			27
28	<b>TOTAL General Administration</b>	237,947	14,106	964,514	1,216,567		1,216,567	(37,222)	1,179,345		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,903,250	324,302	1,514,895	4,742,447		4,742,447	(41,228)	4,701,219		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: 01/01/2007 Ending: 12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			173,998	173,998		173,998		173,998		30
31	Amortization of Pre-Op. & Org.			2,760	2,760		2,760		2,760		31
32	Interest			166,568	166,568		166,568	(4,664)	161,904		32
33	Real Estate Taxes			68,130	68,130		68,130		68,130		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			7,623	7,623		7,623		7,623		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			419,079	419,079		419,079	(4,664)	414,415		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		76,913		76,913		76,913		76,913		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops		5,118		5,118		5,118		5,118		41
42	Provider Participation Fee			65,154	65,154		65,154		65,154		42
43	Other (specify):* <b>Inc taxes</b>			4,827	4,827		4,827		4,827		43
44	<b>TOTAL Special Cost Centers</b>		82,031	69,981	152,012		152,012		152,012		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,903,250	406,333	2,003,955	5,313,538		5,313,538	(45,892)	5,267,646		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: 01/01/2007

Ending: 12/31/2007

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,006)	1		4
5	Telephone, TV & Radio in Resident Rooms	(6,040)	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	(4,664)	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	(150)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,975)	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	(5,778)	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 copying charges	(202)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (46,267)		\$	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	375	19	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 375		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (45,892)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Columbia Convalescent Center

ID# 0037556

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Columbia Convalescent Center

# 0037556

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	(4,006)	0	0	0	0	0	0	0	0	0	0	(4,006)	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	<b>TOTAL General Services</b>	<b>(4,006)</b>	<b>0</b>	<b>(4,006)</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	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	<b>TOTAL Health Care and Programs</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</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	375	375	0	0	0	0	0	0	0	0	0	750	19
20	Fees, Subscriptions & Promotions	(5,928)	0	0	0	0	0	0	0	0	0	0	(5,928)	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):*	(8,015)	0	0	0	0	0	0	0	0	0	0	(8,015)	27
28	<b>TOTAL General Administration</b>	<b>(37,020)</b>	<b>375</b>	<b>0</b>	<b>(36,645)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(41,026)</b>	<b>375</b>	<b>0</b>	<b>(40,651)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number Columbia Convalescent Center

# 0037556

Report Period Beginning:

01/01/2007 Ending:

Summary B

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	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	(4,664)	0	0	0	0	0	0	0	0	0	0	(4,664)	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>(4,664)</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>(4,664)</b>	<b>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</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(45,690)</b>	<b>375</b>	<b>0</b>	<b>(45,315)</b>	<b>45</b>								

Facility Name & ID Number Columbia Convalescent Center

# 0037556

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**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	\$ 167,231	SAMAS PARTNERSHIP	0.00%	\$ 167,231	\$	1	
2	V							2	
3	V	19 Accounting fees		SAMAS PARTNERSHIP	0.00%	375	375	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		\$ 167,231			\$ 167,606	\$ *	375	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: 01/01/2007 Ending: 12/31/2007

## 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									\$	1
2										2
3		SEE ATTACHED								3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Columbia Convalescent Center

# 0037556

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3	The Bank of Edwardsville		X	Renovation	\$1,880.00	6/2/2007	200,000	194,267	12/2/2010	6.6250	8,070	3								
4	The Bank of Edwardsville		X	Mortgage	\$20,608.61	12/22/05	2,636,000	2,408,890	8/11/2019	6.1250	153,207	4								
5												5								
<b>Working Capital</b>																				
6												6								
7	1st Insurance Funding		X	Insurance package	\$10,305.00	12/1/06	89,734		8/01/2007	7.9900	2,511	7								
8	The Bank of Edwardsville		X	Working Capital	interest only	12/15/06	500,000	130,000	12/15/2008	Variable	2,780	8								
9	<b>TOTAL Facility Related</b>				\$32,793.61		\$ 3,425,734	\$ 2,733,157			\$ 166,568	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 3,425,734	\$ 2,733,157			\$ 166,568	15								

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

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

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

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

B. Real Estate Taxes

<p><b>Important</b>, 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 2006 report.		\$ 68,635	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.)		\$ 70,364	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 1,729	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 66,401	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. 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 _____ 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.		\$ 68,130	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	77,278	8
	2003	82,368	9
	2004	67,390	10
	2005	67,625	11
	2006	70,364	12
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- 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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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 &amp; Pt Lot 1 Bradington Pl</u>	\$ <u>668.00</u>	\$ <u>668.00</u>
2. <u>04-17-481-005-000</u>	<u>Part Lot 4 Sur 416</u>	\$ <u>17,976.00</u>	\$ <u>17,976.00</u>
3. <u>04-17-481-004-000</u>	<u>Part Lot 4 Sur 416</u>	\$ <u>51,720.00</u>	\$ <u>51,720.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>70,364.00</u>	\$ <u>70,364.00</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        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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

01/01/2007 Ending:

12/31/2007

**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).

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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: \_\_\_\_\_ 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 &amp; ID Number Columbia Convalescent Center

# 0037556

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1991	1991	\$ 2,115,587	\$ 52,890	40	\$ 52,890		\$ 899,125	4
5			1991	1991	48,503		15			47,695	5
6	20		1998	1998	1,170,228	29,256	40	29,256		275,491	6
7											7
8											8
		<b>Improvement Type**</b>									
9		Land Improvements	1991	1991	147,905	7,395	20	7,395		118,940	9
10		Fixed Equipment	1991	1991	24,679		15			24,312	10
11		Alarm System	1992	1992	910		15			910	11
12		Water Softner	1992	1992	8,625	431	15	431		8,481	12
13		Carpet	1993	1993	1,430		12			1,400	13
14		Guttering	1994	1994	899		7			870	14
15		Pavilion	1994	1994	7,400		12			7,400	15
16		Misc Improvements	1995	1995	2,165		10			2,121	16
17		Drainage System	1996	1996	1,374	92	15	92		1,022	17
18		Cold Water Line	1996	1996	6,803	174	39	174		2,035	18
19		A/C Compressor	1996	1996	1,574		7			1,574	19
20		Carpet	1996	1996	591		7			591	20
21		Hot Water Heater	1996	1996	3,473		7			3,473	21
22		Heat Trace & Hot Water Pipes	1996	1996	1,535	102	15	102		1,117	22
23		Furnace and Air conditioning renovation	1997	1997	1,690	70	10	70		1,690	23
24		Day Room Carpet and Window Treatments	1997	1997	7,658		7			7,658	24
25		Telephone/Voice Mail System	1997	1997	14,739		5			14,739	25
26		Entry Area Carpeting	1997	1997	1,080		7			1,080	26
27		UPS Battery Back-up System	1997	1997	733		5			733	27
28		Door	1997	1997	1,485	38	39	38		387	28
29		Fan	1997	1997	1,083	28	39	28		282	29
30		Landscaping	1998	1998	4,030	269	15	269		2,459	30
31		Landscaping	1998	1998	7,429	495	15	495		4,664	31
32		Irrigation System	1998	1998	12,990	866	15	866		8,155	32
33		Parking Lot	1998	1998	15,912	1,061	15	1,061		9,989	33
34		Landscaping	1998	1998	10,479	699	15	699		6,578	34
35		Sidewalks	1998	1998	19,864	1,324	15	1,324		12,470	35
36		Draperies	1998	1998	18,417		5			18,415	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.

Facility Name &amp; ID Number Columbia Convalescent Center

# 0037556

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	\$	\$ 34,655	37
38	Decorating Wallpapering & Painting	1998	49,156	58	5-10 yr	58		49,120	38
39	Alarm Security System	1998	17,574	291	5-7yr	291		17,100	39
40	Attic Ventilating Fans	1998	6,179	618	10	618		5,973	40
41	Storeroom Locks	1998	593		7			593	41
42	Telephone Equipment	1998	1,940	194	10	194		1,859	42
43	Light Fixtures	1998	4,291	429	10	429		4,041	43
44	Therapy Room Sink	1998	1,213		7			1,213	44
45	Signage	1998	116	12	10	12		109	45
46	Site Lighting	1998	5,684		7			5,684	46
47	Landscaping	1999	6,955	464	15	464		3,892	47
48	Water Heater Replacement	1999	35,258	3,526	10	3,526		30,090	48
49	Washer & Dryer	1999	4,600	460	10	460		3,718	49
50	Air Conditioner	1999	8,965	896	10	896		7,451	50
51	Room Renovations	1999	6,778	426	5-10y	426		5,421	51
52	Door Security System	1999	14,347	1,435	10	1,435		12,054	52
53	Landscaping	2000	1,987	132	15	132		971	53
54	Water Heater Replacement	2000	6,848	685	10	685			54
55	Carpeting	2000	1,579	158	10	158		1,184	55
56	Floor Tile	2001	1,546	155	10	155		1,069	56
57	Landscaping	2001	2,127	142	15	142		938	57
58	Evaporator Coil	2001	2,514	251	10	251		1,655	58
59	Vinal Trim Window	2001	6,459	646	10	646		3,983	59
60	Painting	2001	6,080	608	10	608		3,699	60
61	Telephone System	2001	1,631		5			1,631	61
62	Alert System	2001	6,443	920	7	920		5,292	62
63	Alert System	2002	6,442	921	7	921		5,292	63
64	Landscaping	2002	417	28	15	28		160	64
65	Heating Cooling	2002	7,477	748	10	748		4,176	65
66	Carpeting, fire doors, electrical	2002	4,968	497	10	497		2,669	66
67	Parking Lot	2003	3,420	228	15	228		931	67
68	Hot Water Heater	2002	2,380	238	10	238		1,408	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,924,076	\$ 114,040		\$ 114,040	\$	\$ 1,703,887	70

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

Facility Name &amp; ID Number Columbia Convalescent Center

# 0037556

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,924,076	\$ 114,040		\$ 114,040	\$	\$ 1,703,887	1
2	Bathroom impr	2003	624	62	10	62		265	2
3	Air Conditioning/temp control	2003	3,604	360	10	360		1,531	3
4	Nurse Call System	2003	1,075	107	10	107		448	4
5	Hot water system	2003	5,603	560	10	560		2,615	5
6	Payroll wiring/ time system	2003	2,000	200	10	200		967	6
7	Valves,adapters, coils A/C	2003	3,626	363	10	363		1,688	7
8	Security upgrades	2003	522	52	10	52		239	8
9	Control joints	2003	1,019	102	10	102		475	9
10	Parking lot sealer/stripping	2004	300	20	15	20		78	10
11	Guard rails, concrete work docking area	2004	17,387	1,159	15	1,159		3,534	11
12	New Lighting	2004	21,784	2,178	10	2,178		7,753	12
13	Painting	2004	2,115	211	10	211		720	13
14	Air Conditioning/Hot water system	2004	8,069	807	10	807		3,132	14
15	Wiring call system, security system	2004	2,917	292	10	292		1,086	15
16	Flooring	2004	1,777	178	10	178		607	16
17	Kitchen Hood, grill	2004	2,871	287	10	287		899	17
18	Fire dampers	2004	2,600	260	10	260		780	18
19	Generator tank	2004	3,632	363	10	363		1,392	19
20	Plumbing	2004	974	97	10	97		373	20
21	Ventilation Laundry dept	2004	15,505	1,551	10	1,551		5,556	21
22	Thermocouplers	2004	1,208	121	10	121		473	22
23	Awnings	2005	2,210	221	10	221		562	23
24	Doors	2005	3,981	398	10	398		1,095	24
25	Plumbing and filter system	2005	9,949	995	10	995		2,819	25
26	Underground piping	2005	1,885	188	10	188		424	26
27	Handrails	2005	4,518	452	10	452		979	27
28	Landscaping	2005	1,300	87	15	87		188	28
29	Doors and kickplates	2006	1,438	144	10	144		177	29
30	Plumbing,water conditioners, heaters	2006	20,427	2,354	10	2,354		3,751	30
31	Air conditioning	2006	7,979	798	10	798		997	31
32	cubicle curtains	2006	294	42	7	42		59	32
33	sidewalk and landscaping	2006	9,320	621	15	621		725	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,086,589	\$ 129,670		\$ 129,670	\$	\$ 1,750,274	34

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

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 12B, Carried Forward		\$ 4,086,589	\$ 129,670		\$ 129,670	\$	\$ 1,750,274	1
2	Sidewalk	2007	2,700	165	15	165		165	2
3	Landscaping	2007	400	30	10	30		30	3
4	New flooring	2007	13,998	583	10	583		583	4
5	Laundry	2007	12,461	1,038	10	1,038		1,038	5
6	Fireproofing	2007	10,250	312	10	312		312	6
7	Paint, drywall, molding, panels	2007	35,163	1,317	10	1,317		1,317	7
8	lighting fixtures	2007	23,181	1,151	10	1,151		1,151	8
9	water lines, heater	2007	10,307	54	10	54		54	9
10	cabinets,cable,cubicle,hand rails	2007	2,640	62	10	62		62	10
11	fiberglass panels	2007	2,520	84	10	84		84	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,200,209	\$ 134,466		\$ 134,466	\$	\$ 1,755,070	34

\*\*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: 01/01/2007 Ending: 12/31/2007

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	\$ 301,615	\$ 30,521	\$ 30,521	\$	5-15	\$ 200,875	71
72	Current Year Purchases	151,125	9,011	9,011		5-10	9,011	72
73	Fully Depreciated Assets	462,385					462,385	73
74								74
75	TOTALS	\$ 915,125	\$ 39,532	\$ 39,532	\$		\$ 672,271	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)	\$ 5,431,132	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 173,998	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 173,998	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)	\$ 2,465,555	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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	<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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 7,623 Description: Office 4256, nursing 3367

(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	<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 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)	
<b>TOTAL TRAINED</b>	

- (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	\$	1,584	\$ 105,101	\$ 200	1,584	\$ 105,301	1
2	Licensed Speech and Language Development Therapist	10-A-3	hrs		510	37,131		510	37,131	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-A-3	hrs		2,112	121,324	650	2,112	121,974	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				76,913		76,913	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	4,206	\$ 263,556	\$ 77,763	4,206	\$ 341,319	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: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 139,963	\$	1
2	Cash-Patient Deposits	9,795		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	666,128		3
4	Supply Inventory (priced at <u>cost</u> )	24,134		4
5	Short-Term Investments			5
6	Prepaid Insurance	72,540		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>prepaid mgmt fees</u>	12,769		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 925,329	\$	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	907,590		15
16	Equipment, at Historical Cost	953,359		16
17	Accumulated Depreciation (book methods)	(2,465,555)		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>	14,630		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,980,226	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,905,555	\$	25

		1	2	
		Operating	After	
			Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 205,927	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,795		28
29	Short-Term Notes Payable	263,858		29
30	Accrued Salaries Payable	160,432		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,483		31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,401		32
33	Accrued Interest Payable	7,075		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 722,971	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	184,491		39
40	Mortgage Payable	2,284,808		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>	\$ 2,469,299	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,192,270	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 713,285	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,905,555	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 729,942	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 729,942	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	303,343	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (16,657)</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 713,285</b>	24 *

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

Facility Name & ID Number Columbia Convalescent Center# 0037556Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	\$ 5,040,223	1
2	Discounts and Allowances for all Levels	(118,231)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,921,992	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	641,106	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 641,106	8
<b>C. Other Operating Revenue</b>			
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	7,800	13
14	Non-Patient Meals	4,006	14
15	Telephone, Television and Radio	7,958	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,454	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 35,218	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,665	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,665	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Vending	8,476	28
28a	Misc	5,424	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 13,900	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,616,881	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,022,308	31
32	Health Care	2,503,572	32
33	General Administration	1,216,567	33
<b>B. Capital Expense</b>			
34	Ownership	419,079	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	86,858	35
36	Provider Participation Fee	65,154	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,313,538	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	303,343	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 303,343	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: 01/01/2007

Ending:

12/31/2007

**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	1,918	2,150	\$ 86,479	\$ 40.22	1
2	Assistant Director of Nursing	1,880	2,098	63,942	30.48	2
3	Registered Nurses	3,702	4,065	105,076	25.85	3
4	Licensed Practical Nurses	24,347	26,305	513,994	19.54	4
5	CNAs & Orderlies	76,449	82,399	1,008,568	12.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,980	5,432	66,064	12.16	8
9	Activity Director					9
10	Activity Assistants	8,526	9,226	88,019	9.54	10
11	Social Service Workers	3,672	4,043	61,177	15.13	11
12	Dietician					12
13	Food Service Supervisor	2,004	2,255	32,877	14.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,370	5,791	74,123	12.80	15
16	Dishwashers	14,751	15,613	122,878	7.87	16
17	Maintenance Workers	3,980	4,304	60,603	14.08	17
18	Housekeepers	19,588	21,082	191,842	9.10	18
19	Laundry	8,174	8,730	74,731	8.56	19
20	Administrator	2,041	2,312	96,832	41.88	20
21	Assistant Administrator					21
22	Other Administrative	3,647	4,069	74,656	18.35	22
23	Office Manager					23
24	Clerical	5,690	6,091	66,459	10.91	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 nurse admin</u>	5,097	5,452	114,930	21.08	33
34	TOTAL (lines 1 - 33)	195,816	211,417	\$ 2,903,250 *	\$ 13.73	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	132	\$ 6,597	L1 C3	35
36	Medical Director	varies	10,800	L9 C3	36
37	Medical Records Consultant	24	959	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	21	720	L10 C3	39
40	Physical Therapy Consultant	155	9,731	L10 C3	40
41	Occupational Therapy Consultant	62	4,188	L10 C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	506	L10 C3	43
44	Activity Consultant				44
45	Social Service Consultant	38	1,317	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	440	\$ 34,818		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	115	\$ 3,247	L10 C3	50
51	Licensed Practical Nurses	831	24,858	L10 C3	51
52	Certified Nurse Assistants/Aides	181	3,925	L10 C3	52
53	TOTAL (lines 50 - 52)	1,127	\$ 32,030		53





Facility Name &amp; ID Number Columbia Convalescent Center

**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? 7 yr
- (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. \$ 65,154  
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? yes Indicate the amount. \$ 4,006
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.