

Facility Name & ID Number Columbia Convalescent Center

0037556 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF	1,889	901	2,204	4,994	8
9	SNF/PED					9
10	ICF	12,762	19,054		31,816	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,651	19,955	2,204	36,810	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.75%

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)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 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 2,204

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	255,122	11,113	12,916	279,151		279,151		279,151		1
2	Food Purchase		197,853		197,853		197,853	(3,899)	193,954		2
3	Housekeeping	212,218	21,335	954	234,507		234,507		234,507		3
4	Laundry	73,715	15,876	2,032	91,623		91,623		91,623		4
5	Heat and Other Utilities			179,039	179,039		179,039		179,039		5
6	Maintenance	64,322	24,989	31,423	120,734		120,734		120,734		6
7	Other (specify):*										7
8	TOTAL General Services	605,377	271,166	226,364	1,102,907		1,102,907	(3,899)	1,099,008		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,301,130	59,484	352,811	2,713,425	(219,276)	2,494,149		2,494,149		10
10a	Therapy					219,276	219,276		219,276		10a
11	Activities	96,242	9,658	726	106,626		106,626		106,626		11
12	Social Services	52,684	25	2,859	55,568		55,568		55,568		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,450,056	69,167	380,396	2,899,619		2,899,619		2,899,619		16
	C. General Administration										
17	Administrative	85,671		110,723	196,394		196,394		196,394		17
18	Directors Fees										18
19	Professional Services			22,841	22,841	100	22,941	(1,241)	21,700		19
20	Dues, Fees, Subscriptions & Promotions			33,376	33,376		33,376	(5,861)	27,515		20
21	Clerical & General Office Expenses	150,319	11,934	68,754	231,007	(100)	230,907		230,907		21
22	Employee Benefits & Payroll Taxes			555,715	555,715		555,715		555,715		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,196	14,196		14,196	(2,492)	11,704		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			106,346	106,346		106,346	(23,460)	82,886		26
27	Other (specify):* cable TV			6,692	6,692		6,692	(6,692)			27
28	TOTAL General Administration	235,990	11,934	918,643	1,166,567		1,166,567	(39,746)	1,126,821		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,291,423	352,267	1,525,403	5,169,093		5,169,093	(43,645)	5,125,448		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:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			185,925	185,925		185,925		185,925			30
31	Amortization of Pre-Op. & Org.			2,760	2,760		2,760		2,760			31
32	Interest			135,517	135,517		135,517	(403)	135,114			32
33	Real Estate Taxes			90,210	90,210		90,210		90,210			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,863	22,863		22,863		22,863			35
36	Other (specify):*											36
37	TOTAL Ownership			437,275	437,275		437,275	(403)	436,872			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		67,278		67,278		67,278		67,278			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		5,487		5,487		5,487		5,487			41
42	Provider Participation Fee			65,152	65,152		65,152		65,152			42
43	Other (specify):*			4,224	4,224		4,224		4,224			43
44	TOTAL Special Cost Centers		72,765	69,376	142,141		142,141		142,141			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,291,423	425,032	2,032,054	5,748,509		5,748,509	(44,048)	5,704,461			45

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

VI. ADJUSTMENT DETAIL

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

		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	(3,899)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,692)	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	(403)	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	(75)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,922)	20		20
21	Owner or Key-Man Insurance	(23,460)	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	(2,864)	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)	\$ (40,315)		\$	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)	385	var	34
35	Other- Attach Schedule	(4,118)	var	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (3,733)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (44,048)		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					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	
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Columbia Convalescent Center

ID# 0037556

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Out of period legal fees	\$ (1,626)	19	1
2	Undocumented travel expenses	(2,492)	24	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	(4,118)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Columbia Convalescent Center# 0037556

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,899)	0	0	0	0	0	0	0	0	0	0	(3,899)	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	(3,899)	0	0	0	0	0	0	0	0	0	0	(3,899)	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	(1,626)	385	0	0	0	0	0	0	0	0	0	(1,241)	19
20	Fees, Subscriptions & Promotions	(5,861)	0	0	0	0	0	0	0	0	0	0	(5,861)	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	(2,492)	0	0	0	0	0	0	0	0	0	0	(2,492)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(23,460)	0	0	0	0	0	0	0	0	0	0	(23,460)	26
27	Other (specify):*	(6,692)	0	0	0	0	0	0	0	0	0	0	(6,692)	27
28	TOTAL General Administration	(40,131)	385	0	(39,746)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(44,030)	385	0	(43,645)	29								

STATE OF ILLINOIS

Facility Name & ID Number Columbia Convalescent Center# 0037556

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
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	(403)	0	0	0	0	0	0	0	0	0	0	(403)	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	(403)	0	0	0	0	0	0	0	0	0	0	(403)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(44,433)	385	0	0	0	0	0	0	0	0	0	(44,048)	45

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
		See Attached				

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	\$ 110,723	SAMAS PARTNERSHIP	0.00%	\$ 110,723	\$	1
2	V							2
3	V	19 Accounting fees		SAMAS PARTNERSHIP	0.00%	385		385 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		\$ 110,723			\$ 111,108	\$ *	385 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:

01/01/2009

Ending:

12/31/2009

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	169,464	10	14.00	Mgmt Fees	\$ 46,963	17-3	1
2	Michael Riley	Secretary	Owner/Admin	16.00	0	20	30.00	Mgmt Fees	34,149	17-3	2
3	Steven Brant	Treasurer	Owner/Admin	4.00	0	24	35.00	Mgmt Fees	29,611	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 110,723		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:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Columbia Convalescent Center

0037556

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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										
										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																			
2	The Bank of Edwardsville	X	Renovation	\$1,880.00	6/2/2007	200,000	170,933	12/2/2010	6.6250	8,915									
3	The Bank of Edwardsville	X	Mortgage	\$20,608.61	12/22/05	2,636,000	2,123,453	8/11/2019	6.1250	122,513									
4																			
5																			
Working Capital																			
6																			
7	The Bank of Edwardsville	X	Working Capital	interest only	12/15/06	500,000		12/15/10	Variable	4,089									
8																			
9	TOTAL Facility Related			\$22,488.61		\$ 3,336,000	\$ 2,294,386			\$ 135,517									
B. Non-Facility Related*																			
10																			
11																			
12																			
13																			
14	TOTAL Non-Facility Related					\$	\$			\$									
15	TOTALS (line 9+line14)					\$ 3,336,000	\$ 2,294,386			\$ 135,517									

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.)

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0037556

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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:

	1	2	3	4	
A. Land.	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

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		\$ 1,004,904	4
5			1991	1991	48,503		15			47,695	5
6	20		1998	1998	1,170,228	29,256	40	29,256		334,003	6
7											7
8											8
	Improvement Type**										
9		Land Improvements	1991		147,905	7,395	20	7,395		133,731	9
10		Fixed Equipment	1991		24,679		15			24,312	10
11		Alarm System	1992		910		15			910	11
12		Water Softner	1992		8,625		15			8,481	12
13		Carpet	1993		1,430		12			1,400	13
14		Guttering	1994		899		7			870	14
15		Pavilion	1994		7,400		12			7,400	15
16		Misc Improvements	1995		2,165		10			2,121	16
17		Drainage System	1996		1,374	92	15	92		1,206	17
18		Cold Water Line	1996		6,803	174	39	174		2,384	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		1,322	22
23		Furnace and Air conditioning renovation	1997		1,690		10			1,690	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		463	28
29		Fan	1997		1,083	28	39	28		337	29
30		Landscaping	1998		4,030	269	15	269		2,996	30
31		Landscaping	1998		7,429	495	15	495		5,655	31
32		Irrigation System	1998		12,990	866	15	866		9,887	32
33		Parking Lot	1998		15,912	1,061	15	1,061		12,111	33
34		Landscaping	1998		10,479	699	15	699		7,976	34
35		Sidewalks	1998		19,864	1,324	15	1,324		15,119	35
36		Draperies	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

See Page 12A, Line 70 for total

Facility Name & ID Number Columbia Convalescent Center

0037556

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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	\$	10	\$	\$	\$ 36,940	37
38	Decorating Wallpapering & Painting	1998	49,156		5-10 yr			49,154	38
39	Alarm Security System	1998	17,574		5-7yr			17,246	39
40	Attic Ventilating Fans	1998	6,179		10			6,179	40
41	Storeroom Locks	1998	593		7			593	41
42	Telephone Equipment	1998	1,940		10			1,940	42
43	Light Fixtures	1998	4,291		10			4,291	43
44	Therapy Room Sink	1998	1,213		7			1,213	44
45	Signage	1998	116		10			116	45
46	Site Lighting	1998	5,684		7			5,684	46
47	Landscaping	1999	6,955	464	15	464		4,819	47
48	Water Heater Replacement	1999	35,258	1,642	10	1,642		35,258	48
49	Washer & Dryer	1999	4,600	422	10	422		4,600	49
50	Air Conditioner	1999	8,965	617	10	617		8,965	50
51	Room Renovations	1999	6,778	248	5-10y	248		6,778	51
52	Door Security System	1999	14,347	859	10	859		14,347	52
53	Landscaping	2000	1,987	132	15	132		1,235	53
54	Water Heater Replacement	2000	6,848	685	10	685		6,791	54
55	Carpeting	2000	1,579	158	10	158		1,500	55
56	Floor Tile	2001	1,546	155	10	155		1,379	56
57	Landscaping	2001	2,127	142	15	142		1,221	57
58	Evaporator Coil	2001	2,514	251	10	251		2,158	58
59	Vinal Trim Window	2001	6,459	646	10	646		5,275	59
60	Painting	2001	6,080	608	10	608		4,915	60
61	Telephone System	2001	1,631		5			1,631	61
62	Alert System	2001	6,443	230	7	230		6,443	62
63	Alert System	2002	6,442	230	7	230		6,442	63
64	Landscaping	2002	417	28	15	28		216	64
65	Heating Cooling	2002	7,477	748	10	748		5,672	65
66	Carpeting, fire doors, electrical	2002	4,968	497	10	497		3,663	66
67	Parking Lot	2003	3,420	228	15	228		1,387	67
68	Hot Water Heater	2002	2,380	238	10	238		1,884	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,924,076	\$ 103,917		\$ 103,917	\$	\$ 1,925,171	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:

01/01/2009 Ending: 12/31/2009

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	\$ 103,917		\$ 103,917	\$	\$ 1,925,171	1
2	Bathroom impr	2003	624	62	10	62		390	2
3	Air Conditioning/temp control	2003	3,604	360	10	360		2,252	3
4	Nurse Call System	2003	1,075	107	10	107		663	4
5	Hot water system	2003	5,603	560	10	560		3,735	5
6	Payroll wiring/ time system	2003	2,000	200	10	200		1,367	6
7	Valves,adapters, coils A/C	2003	3,626	363	10	363		2,413	7
8	Security upgrades	2003	522	52	10	52		344	8
9	Control joints	2003	1,019	102	10	102		679	9
10	Parking lot sealer/stripping	2004	300	20	15	20		118	10
11	Guard rails, concrete work docking area	2004	17,387	1,459	15	1,459		5,852	11
12	New Lighting	2004	21,784	2,178	10	2,178		12,110	12
13	Painting	2004	2,115	211	10	211		1,143	13
14	Air Conditioning/Hot water system	2004	8,069	807	10	807		4,746	14
15	Wiring call system, security system	2004	2,917	292	10	292		1,670	15
16	Flooring	2004	1,777	178	10	178		963	16
17	Kitchen Hood, grill	2004	2,871	287	10	287		1,473	17
18	Fire dampers	2004	2,600	260	10	260		1,300	18
19	Generator tank	2004	3,632	363	10	363		2,119	19
20	Plumbing	2004	974	97	10	97		568	20
21	Ventilation Laundry dept	2004	15,505	1,551	10	1,551		8,657	21
22	Thermocouplers	2004	1,208	121	10	121		715	22
23	Awnings	2005	2,210	221	10	221		1,104	23
24	Doors	2005	3,981	398	10	398		1,891	24
25	Plumbing and filter system	2005	9,949	995	10	995		4,809	25
26	Underground piping	2005	1,885	188	10	188		801	26
27	Handrails	2005	4,518	452	10	452		1,883	27
28	Landscaping	2005	1,300	87	15	87		361	28
29	Doors and kickplates	2006	1,438	144	10	144		465	29
30	Plumbing,water conditioners, heaters	2006	20,427	2,354	10	2,354		8,459	30
31	Air conditioning	2006	7,979	798	10	798		2,593	31
32	cubicle curtains	2006	294	42	7	42		143	32
33	sidewalk and landscaping	2006	9,320	621	15	621		1,967	33
34	TOTAL (lines 1 thru 33)		\$ 4,086,589	\$ 119,847		\$ 119,847	\$	\$ 2,002,924	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:

01/01/2009 Ending: 12/31/2009

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	\$ 119,847		\$ 119,847	\$	\$ 2,002,924	1
2	Sidewalk	2007	2,700	180	15	180		525	2
3	Landscaping	2007	400	40	10	40		110	3
4	New flooring	2007	13,998	1,400	10	1,400		3,383	4
5	Laundry	2007	12,461	1,246	10	1,246		3,531	5
6	Fireproofing	2007	10,250	1,025	10	1,025		2,362	6
7	Paint, drywall, molding, panels	2007	35,163	3,516	10	3,516		8,349	7
8	lighting fixtures	2007	23,181	2,318	10	2,318		5,788	8
9	water lines, heater	2007	10,307	1,031	10	1,031		2,116	9
10	cabinets,cable,cubicle,hand rails	2007	2,640	264	10	264		590	10
11	fiberglass panels	2007	2,520	252	10	252		588	11
12	mulch,shrubs,parking lot	2008	7,751	775	10	775		1,196	12
13	heating/AC	2008	19,554	1,955	10	1,955		2,761	13
14	window treatments	2008	13,410	1,341	10	1,341		2,423	14
15	flooring	2008	27,542	2,754	10	2,754		4,625	15
16	valves and piping	2008	10,571	1,057	10	1,057		1,672	16
17	paint chapel,dining room,nurse station	2008	2,470	247	10	247		371	17
18	counters, door closers regulator	2008	2,212	221	10	221		236	18
19	Curbing/bushes	2009	1,286	75	10	75		75	19
20	Flooring	2009	6,898	502	10	502		502	20
21	HVAC	2009	19,363	1,014	10	1,014		1,014	21
22	Drop Ceiling	2009	1,180	98	10	98		98	22
23	Electrical boxes	2009	1,022	77	10	77		77	23
24	Emergency electrical backup/wiring	2009	3,558	237	10	237		237	24
25	Bathroom remodeling	2009	3,401	227	10	227		227	25
26	Windows	2009	891	22	10	22		22	26
27	Installed new phone system	2009	16,847	983	10	983		983	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,338,165	\$ 142,704		\$ 142,704	\$	\$ 2,046,785	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:

01/01/2009

Ending:

12/31/2009

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	\$ 393,439	\$ 39,630	\$ 39,630		5-10	\$ 196,489	71
72	Current Year Purchases	47,282	3,591	3,591		5-10	3,591	72
73	Fully Depreciated Assets	552,756					552,756	73
74	rounding	(3)						74
75	TOTALS	\$ 993,474	\$ 43,221	\$ 43,221			\$ 752,836	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)	\$ 5,647,437	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 185,925	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 185,925	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)	\$ 2,837,835	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	TOTAL				\$			7

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 22,863 Description: office equipment 5968/ dietary equipment 16895

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* 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	\$	1,444	\$ 87,809	\$ 289	1,444	\$ 88,098	1
2	Licensed Speech and Language Development Therapist	10-A-3	hrs		254	19,386		254	19,386	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-A-3	hrs		1,883	108,153	639	1,883	108,792	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 prescripts				59,966		59,966	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Lab/x-ray</u>	39-2					7,312		7,312	12
13	Other (specify): _____									13
14	TOTAL			\$	3,581	\$ 215,348	\$ 68,206	3,581	\$ 283,554	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: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (18,848)	\$	1
2	Cash-Patient Deposits	28,390		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	442,696		3
4	Supply Inventory (priced at <u>cost</u>)	30,032		4
5	Short-Term Investments			5
6	Prepaid Insurance	59,351		6
7	Other Prepaid Expenses	4,010		7
8	Accounts Receivable (owners or related parties)	21,502		8
9	Other(specify): <u>Due from employees</u>	28,206		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 595,339	\$	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	1,045,544		15
16	Equipment, at Historical Cost	1,031,711		16
17	Accumulated Depreciation (book methods)	(2,837,835)		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>	9,111		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,818,733	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,414,072	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 249,817	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,390		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,130		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,436		31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,115		32
33	Accrued Interest Payable	5,037		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 459,925	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	170,933		39
40	Mortgage Payable	2,123,454		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)	\$ 2,294,387	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,754,312	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 659,760	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,414,072	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 786,793	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 786,793	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	152,967	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	(280,000)	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)	\$ (127,033)	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)	\$ 659,760	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Columbia Convalescent Center

0037556

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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	\$ 5,346,077	1
2	Discounts and Allowances for all Levels	(46,223)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,299,854	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	417,954	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 417,954	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	7,800	13
14	Non-Patient Meals	3,899	14
15	Telephone, Television and Radio	7,705	15
16	Rental of Facility Space		16
17	Sale of Drugs	119,291	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	15,294	20
21	Other Medical Services	20,105	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 174,094	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	403	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 403	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	vending	8,063	28
28a	misc	1,108	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,171	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,901,476	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,102,907	31
32	Health Care	2,899,619	32
33	General Administration	1,166,567	33
B. Capital Expense			
34	Ownership	437,275	34
C. Ancillary Expense			
35	Special Cost Centers	76,989	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)*	\$ 5,748,509	40
41	Income before Income Taxes (line 30 minus line 40)**	152,967	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 152,967	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? no 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: **01/01/2009**

Ending:

12/31/2009

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	1,869	2,064	\$ 72,456	\$ 35.10	1
2	Assistant Director of Nursing	1,857	2,033	57,876	28.47	2
3	Registered Nurses	15,671	16,283	460,260	28.27	3
4	Licensed Practical Nurses	25,102	28,497	544,882	19.12	4
5	CNAs & Orderlies	86,631	97,042	1,104,795	11.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,217	4,844	60,862	12.56	8
9	Activity Director					9
10	Activity Assistants	9,324	10,283	96,242	9.36	10
11	Social Service Workers	3,201	3,426	52,684	15.38	11
12	Dietician					12
13	Food Service Supervisor	2,063	2,263	40,153	17.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,025	6,543	82,812	12.66	15
16	Dishwashers	14,875	15,910	132,158	8.31	16
17	Maintenance Workers	4,320	4,838	64,322	13.30	17
18	Housekeepers	22,205	24,870	212,218	8.53	18
19	Laundry	7,716	8,562	73,715	8.61	19
20	Administrator	2,051	2,328	85,671	36.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,957	12,272	150,318	12.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	218,084	242,058	\$ 3,291,424 *	\$ 13.60	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	186	\$ 7,551	1-3	35
36	Medical Director	monthly fee	24,000	9-3	36
37	Medical Records Consultant	41	2,283	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly fee	720	10-3	39
40	Physical Therapy Consultant	235	14,329	10-3	40
41	Occupational Therapy Consultant	78	5,544	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	23	1,519	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	48	2,859	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	611	\$ 58,805		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	48	\$ 1,955	10-3	50
51	Licensed Practical Nurses	1,086	35,195	10-3	51
52	Certified Nurse Assistants/Aides	1,430	28,390	10-3	52
53	TOTAL (lines 50 - 52)	2,564	\$ 65,540		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
David Wendler	Administrator		\$ 85,671	Workers' Compensation Insurance	\$ 127,698	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	21,705	Advertising: Employee Recruitment	20,658		
				FICA Taxes	249,886	Health Care Worker Background Check			
				Employee Health Insurance	132,136	(Indicate # of checks performed <u>201</u>)	3,014		
				Employee Meals		Patient Background Checks	141		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Sec of State	833		
				401K	1,521	City of Columbia	231		
				employee relations	22,769	Various dues and subs	789		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 85,671	TOTAL (agree to Schedule V, line 22, col.8)		\$ 27,515			
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount				Non-allowable advertising ()		
SAMAS Management Fees			\$ 110,723				Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 110,723	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type	Amount							
Wessells and Pautsch	Legal	\$ 353					Out-of-State Travel	\$	
Elvidge & Kelley	Legal	5,937							
Duane Morris	Legal	986					In-State Travel	5,394	
Hinshaw Culbertson	Legal	421							
J W Boyle	Accounting/tax	15,244			N/A		Seminar Expense	6,310	
reclass		(100)							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 22,841	TOTAL		\$	Entertainment Expense ()		
							TOTAL (agree to Sch. V, line 24, col. 8)		\$ 11,704

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Columbia Convalescent Center# 0037556Report Period Beginning: 01/01/2009 Ending: 12/31/2009**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? 5-10 years
- (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? Yes 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? Yes
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?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (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.