



Facility Name & ID Number Columbus Manor Residential Care Home

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

**III. STATISTICAL DATA**

**A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds**

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	189	Intermediate (ICF)	189	68,985	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	189	TOTALS	189	68,985	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	39,376			39,376	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,376			39,376	14

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

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

13 (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)**

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

**G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?**

YES  NO

**H. Does the BALANCE SHEET (page 17) reflect any non-care assets?**

YES  NO

**I. On what date did you start providing long term care at this location?**

Date started 0/0/66

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

YES  Date 5/1/79 NO

**K. Was the facility certified for Medicare during the reporting year?**

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary None

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	181,191	147	9,504	190,842		190,842		190,842		1
2	Food Purchase		313,606		313,606	(24,304)	289,302		289,302		2
3	Housekeeping	78,924		3,064	81,988		81,988		81,988		3
4	Laundry	36,659	8,120	1,871	46,650		46,650		46,650		4
5	Heat and Other Utilities			113,865	113,865		113,865		113,865		5
6	Maintenance	68,007	19,742	129,326	217,075		217,075		217,075		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	364,781	341,615	257,630	964,026	(24,304)	939,722		939,722		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	775,968	36,699	20,149	832,816		832,816		832,816		10
10a	Therapy										10a
11	Activities	50,159	65	1,297	51,521		51,521		51,521		11
12	Social Services	100,805		1,331	102,136		102,136		102,136		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	926,932	36,764	22,777	986,473		986,473		986,473		16
	<b>C. General Administration</b>										
17	Administrative										17
18	Directors Fees										18
19	Professional Services			107,182	107,182		107,182		107,182		19
20	Dues, Fees, Subscriptions & Promotions			9,578	9,578		9,578	(2,698)	6,880		20
21	Clerical & General Office Expenses	47,228	3,796	32,657	83,681		83,681	(3,796)	79,885		21
22	Employee Benefits & Payroll Taxes			220,007	220,007	29,078	249,085		249,085		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,240	2,240		2,240		2,240		24
25	Other Admin. Staff Transportation			16,596	16,596	3,500	20,096	(2,010)	18,086		25
26	Insurance-Prop.Liab.Malpractice			112,186	112,186	(8,274)	103,912		103,912		26
27	Other (specify):*			127,297	127,297		127,297	(168,228)	(40,931)		27
28	<b>TOTAL General Administration</b>	47,228	3,796	627,743	678,767	24,304	703,071	(176,732)	526,339		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,338,941	382,175	908,150	2,629,266		2,629,266	(176,732)	2,452,534		29

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

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

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

## 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	
	<b>D. Ownership</b>											
30	Depreciation			61,576	61,576		61,576	13,333	74,909			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,437	43,437		43,437	29,035	72,472			32
33	Real Estate Taxes			178,379	178,379		178,379		178,379			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* <b>II Replacement Tax</b>			8,505	8,505		8,505	(8,505)				36
37	<b>TOTAL Ownership</b>			771,897	771,897		771,897	(446,137)	325,760			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,695	874	9,569		9,569		9,569			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,400	104,400		104,400		104,400			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		8,695	105,274	113,969		113,969		113,969			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,338,941	390,870	1,785,321	3,515,132		3,515,132	(622,869)	2,892,263			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,796)	21		13
14	Non-Care Related Interest	(40,931)	27		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,010)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(125,122)	27		18
19	Entertainment				19
20	Contributions	(2,175)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,505)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,698)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (185,237)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(437,632)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (437,632)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (622,869)		37

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

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

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

<b>BHF USE ONLY</b>							
48		49		50		51	
							52

Columbus Manor Residential Care Home

ID# 0007781

Report Period Beginning: 1/1/12

Ending: 12/31/12

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 Columbus Manor Residential Care Home

# 0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</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>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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,698)	0	0	0	0	0	0	0	0	0	0	(2,698)	20
21	Clerical & General Office Expenses	(3,796)	0	0	0	0	0	0	0	0	0	0	(3,796)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(2,010)	0	0	0	0	0	0	0	0	0	0	(2,010)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(168,228)	0	0	0	0	0	0	0	0	0	0	(168,228)	27
28	<b>TOTAL General Administration</b>	<b>(176,732)</b>	<b>0</b>	<b>(176,732)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(176,732)</b>	<b>0</b>	<b>(176,732)</b>	<b>29</b>									

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	13,333	0	0	0	0	0	0	0	0	0	13,333	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	29,035	0	0	0	0	0	0	0	0	0	29,035	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(480,000)	0	0	0	0	0	0	0	0	0	(480,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(8,505)	0	0	0	0	0	0	0	0	0	0	(8,505)	36
37	<b>TOTAL Ownership</b>	<b>(8,505)</b>	<b>(437,632)</b>	<b>0</b>	<b>(446,137)</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 (sum of lines 29, 37 &amp; 44)</b>	<b>(185,237)</b>	<b>(437,632)</b>	<b>0</b>	<b>(622,869)</b>	<b>45</b>								

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Patrick J O'Brien	50					
Daniel J O'Brien	50					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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	34 Rent	\$ 480,000	CM LLC	0.00%	\$	(480,000)	1
2	V	30 Depreciation		CM LLC	0.00%	13,333	13,333	2
3	V	32 Interest		CM LLC	0.00%	16,910	16,910	3
4	V	32 Loan Expense		CM LLC	0.00%	12,125	12,125	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 480,000			\$ 42,368	\$ * (437,632)	14

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

Facility Name & ID Number

Columbus Manor Residential Care Home

# 0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

**VII. RELATED PARTIES**

**A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	Patrick J O'Brien	Administrator	CEO Administrato	50.00	0	40	100.00		\$ 0	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

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

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Lightstar Financial		X	Revolving Credit	varies	varies	\$ 314,438	\$ 50,000	varies	0.0262	\$ 40,931	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 314,438	\$ 50,000			\$ 40,931	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>						\$ 314,438	\$ 50,000			\$ 40,931	15						

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																							
1. Real Estate Tax accrual used on 2011 report.				\$	273,998	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	184,041	2																			
3. Under or (over) accrual (line 2 minus line 1).				\$	(89,957)	3																			
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	268,336	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <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.				\$	178,379	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:	2007	153,168	8	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2011</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>			<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>FOR BHF USE ONLY</b>																									
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
	2008	148,043	9																						
	2009	172,407	10																						
	2010	179,913	11																						
	2011	179,165	12																						
<b>2nd Installment 2010= 85088.97</b>																									
<b>1st Installment 2011= 98952.18</b>																									

**NOTES:**

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

**2011 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Columbus Manor Residential Care Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0007781

CONTACT PERSON REGARDING THIS REPORT Patrick J O'Brien

TELEPHONE 773-378-5490 FAX #: 773-378-7890

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number Columbus Manor Residential Care Home

# 0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,308 B. General Construction Type: Exterior Brick Frame Fire Resistant Number of Stories 2

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).

Blank lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Building Site, 41,988, 1965-1978, \$ 34,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 41,988, (blank), \$ 34,000, 3.

Facility Name & ID Number Columbus Manor Residential Care Home

# 0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	129	1965	1955	\$ 179,090	\$	30	\$	\$	\$ 179,090	4
5	12		1969	67,135		30			67,135	5
6	48	1969	1973	401,170		30			401,170	6
7										7
8										8
<b>Improvement Type**</b>										
9	Sidewalk		1966	1,309		20			1,309	9
10	Sidewalk		1967	1,819		20			1,819	10
11	Fence		1970	5,795		15			5,795	11
12	Remodeling		1970	26,600		30			26,600	12
13	Sprinkler System		1971	39,406		25			39,406	13
14	Tile Flooring		1971	12,097		20			12,097	14
15	Additions		1972	89,417		30			89,417	15
16	Stairs Porch Enclosed		1972	19,211		30			19,211	16
17	Roofing Replaced		1972	3,783		30			3,783	17
18	Canopy		1972	1,339		20			1,339	18
19	Fencing		1972	2,016		15			2,016	19
20	Tile Floors		1973	4,718		20			4,718	20
21	Additions		1974	30,006		30			30,006	21
22	Chain Link Fence		1974	3,589		15			3,589	22
23	Sprinkler System		1974	4,664		25			4,664	23
24	Nurses Station		1975	15,635		20			15,635	24
25	Switching Tiling		1975	13,706		20			13,706	25
26	Additions		1976	14,351		30			14,351	26
27	Plumbing and Heating		1976	20,000		25			20,000	27
28	Tiles and Toilets		1976	39,685		20			39,685	28
29	Sprinkler System		1976	1,868		25			1,868	29
30	Tops and Caulking		1976	52,683		20			52,683	30
31	Tile		1976	6,796		20			6,796	31
32	Retile Building		1977	53,525		20			53,525	32
33	Plastering		1977	10,920		20			10,920	33
34	Carpentry		1978	5,152		20			5,152	34
35	Tile		1978	11,775		20			11,775	35
36	Tuckpointing		1980	5,600		20			5,600	36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Columbus Manor Residential Care Home

# 0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Hot Water Heater	1981	\$ 971	\$	10	\$	\$	\$ 971	37
38	Doors, etc	1981	1,360		20			1,360	38
39	Ceramic Tile	1981	24,262		20			24,262	39
40	Additions	1982	14,743		20			14,743	40
41	Windows	1983	13,166		20			13,166	41
42	Windows	1987	2,365		20			2,365	42
43	Cameras	1987	1,091		20			1,091	43
44	Roof Improvement	1988	3,700		20			3,700	44
45	Heater	1990	1,240		10			1,240	45
46	Doors, etc	1990	3,543		20			3,543	46
47	Electrical	1990	2,202		20			2,202	47
48	Exit Doors	1991	19,211		20			19,211	48
49	Doors, etc	1991	14,655		20			14,655	49
50	Electrical	1991	3,507		20			3,507	50
51	New Door	1992	1,330	27	20	27		1,330	51
52	Roof Improvement	1992	8,950	217	20	217		8,950	52
53	Windows	1992	3,150	72	20	72		3,150	53
54	Exit/Interior Doors	1993	6,100	305	20	305		5,644	54
55	Remodel Nurse's Station	1994	16,000	800	20	800		15,200	55
56	Outside Door	1994	2,882	144	20	144		2,737	56
57	Remodel Nurse's Station	1994	20,300	1,015	20	1,015		19,285	57
58	Roof Replacement	1995	28,751	1,438	20	1,438		25,882	58
59	Remodel Nurse's Station	1995	17,710	886	20	886		15,946	59
60	Generator	1998	80,000		10			80,000	60
61	Air Conditioner/Monitor	1998	2,098		10			2,098	61
62	Hydra Electric	1999	900		10			900	62
63	DeCarlo Construction	1999	4,900	245	20	245		3,430	63
64	Storm Windows	1999	6,059	303	20	303		4,242	64
65	Wall Repair	1999	3,098	155	20	155		2,170	65
66	AC Prep	1999	1,824	92	20	92		1,288	66
67	New Fans	1999	1,932	97	20	97		1,358	67
68	AC Prep	1999	2,168	109	20	109		1,526	68
69	Exhaust Fans	1999	9,450	473	20	473		6,622	69
70	TOTAL (lines 4 thru 69)		\$ 1,468,478	\$ 6,378		\$ 6,378	\$	\$ 1,452,634	70

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

Facility Name &amp; ID Number Columbus Manor Residential Care Home

# 0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,468,478	\$ 6,378		\$ 6,378	\$	\$ 1,452,634	1
2	Radiator	2000	10,900	545	20	545		7,085	2
3	PTAK Unit	2000	8,606	431	20	431		5,595	3
4	Four Baseboard Heaters	2001	1,778	89	20	89		1,024	4
5	Nursing Department Cabinets	2006	5,948	298	20	298		3,212	5
6	Front Sign	2007	6,889	460	15	460		2,530	6
7	New Doors	2007	13,676	912	15	912		5,016	7
8	Plumbing Upgrades	2007	8,580	572	15	572		2,873	8
9	New Patio	2007	2,200	147	15	147		809	9
10	Heating Improvements	2007	4,400	294	15	294		1,617	10
11	Courtyard Improvements	2007	9,328	622	15	622		3,421	11
12	11 New Windows	2008	8,371	419	20	419		1,885	12
13	38 New Windows	2008	30,400	1,520	20	1,520		6,840	13
14	New Doors	2008	786	40	20	40		180	14
15	Door Closers	2008	2,549	128	20	128		576	15
16	Fire Alarm Replacement	2008	99,423	4,972	20	4,972		22,374	16
17	Emergency Lighting	2008	20,000	1,000	20	1,000		4,500	17
18	3 Sprinkler Heads	2009	1,890	126	15	126		441	18
19	Roof Repairs	2009	3,500	234	15	234		819	19
20	Basement Drywall Repair & Painting	2009	4,145	276	15	276		966	20
21	Tile Floor	2009	2,900	194	15	194		679	21
22	2 Exterior Doors	2009	4,629	309	15	309		1,082	22
23	2 Exterior Doors	2009	4,017	268	15	268		938	23
24	4 New Windows	2009	1,756	117	15	117		410	24
25	Fire Alarm Improvements	2009	5,939	396	15	396		1,386	25
26	Dining Room Security Door	2009	3,180	212	15	212		742	26
27	Replace Subflooring & Tile in 3 Bathrooms	2010	9,176	459	20	459		919	27
28	Replace Subflooring & Tile in 1 Bathroom	2010	1,948	97	20	97		195	28
29	18 Window Screens	2010	526	53	10	53		105	29
30	Public Phone Privacy Wall	2010	742	37	20	37		75	30
31	AC Installation	2010	3,430	171	20	171		513	31
32	Five new doors installed	2011	4,455	446	10	446		669	32
33	Five fire rated doors installed	2011	6,700	670	10	670		1,005	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,761,245	\$ 22,892		\$ 22,892	\$	\$ 1,533,115	34

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

Facility Name & ID Number Columbus Manor Residential Care Home

# 0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,761,245	\$ 22,892		\$ 22,892	\$	\$ 1,533,115	1
2	Replace Sprinkler Heads	2012	6,382	213	15	213		213	2
3	8 Fire Doors, Escape Window Well	2012	14,635	488	15	488		488	3
4	New Electric Data Entry for Alarm System	2012	7,112	237	15	237		237	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,789,374	\$ 23,830		\$ 23,830	\$	\$ 1,534,053	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 373,067	\$ 22,836	\$ 22,836	\$	5/30	\$ 283,239	71
72	Current Year Purchases	7,256	428	428		5/10	428	72
73	Fully Depreciated Assets	1,196,033				5/30	1,196,033	73
74								74
75	TOTALS	\$ 1,576,356	\$ 23,264	\$ 23,264	\$		\$ 1,479,700	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility B business	Ford Fusion 2008	2007	\$ 33,307	\$ 3,328	\$ 3,328	\$	5	\$ 33,307	76
77	Facility B business	Ford Fusion 2012	2012	28,248	2,825	2,825		5	2,825	77
78										78
79										79
80	TOTALS			\$ 61,555	\$ 6,153	\$ 6,153	\$		\$ 36,132	80

E. Summary of Care-Related Assets

		1 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)	\$ 3,461,285	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 53,247	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 53,247	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,049,885	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

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

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

**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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/12**

(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	\$ 41,593	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	107,245		3
4	Supply Inventory (priced at )	1,800		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 150,638	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,057,032		15
16	Equipment, at Historical Cost	741,388		16
17	Accumulated Depreciation (book methods)	(1,364,925)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 433,495	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 584,133	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ (21,082)	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	261,799		29
30	Accrued Salaries Payable	26,532		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,123		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 455,371	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 455,371	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 128,762	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 584,133	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,225,475</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Year Adjustment to Exchange Account</b>	<b>(96,219)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,129,256</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,155,833)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(844,660)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(2,000,493)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>128,762</b>	<b>24</b> *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,337,923	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,337,923	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	21,375	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 21,375	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,359,299	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	964,026	31
32	Health Care	986,473	32
33	General Administration	678,767	33
<b>B. Capital Expense</b>			
34	Ownership	771,897	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	113,969	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,515,132	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,155,833)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,155,833)	43

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

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

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

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

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

Facility Name & ID Number Columbus Manor Residential Care Home

# 0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	2,468	2,628	101,915	38.78	3
4	Licensed Practical Nurses	14,536	15,540	354,672	22.82	4
5	CNAs & Orderlies	32,188	34,784	317,398	9.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,900	4,204	50,159	11.93	10
11	Social Service Workers	5,422	5,950	100,854	16.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,035	14,279	180,758	12.66	15
16	Dishwashers					16
17	Maintenance Workers	3,840	4,088	68,116	16.66	17
18	Housekeepers	7,539	8,267	78,612	9.51	18
19	Laundry	3,695	4,143	36,558	8.82	19
20	Administrator	2,024	2,080		0.00	20
21	Assistant Administrator	1,991	2,071	46,898	22.65	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,638	98,034	\$ 1,335,940 *	\$ 13.63	34

\* 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	\$ 9,504		35
36	Medical Director			36
37	Medical Records Consultant	7,640		37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	735		44
45	Social Service Consultant	1,331		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 19,210		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>Patrick J O'Brien</u>	<u>Administrator</u>	<u>50</u>	\$ <u>0</u>	<u>Workers' Compensation Insurance</u>	\$ <u>80,178</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>37,714</u>	<u>Advertising: Employee Recruitment</u>	<u>0</u>	
				<u>FICA Taxes</u>	<u>102,479</u>	<u>Health Care Worker Background Check</u>	<u>1,050</u>	
				<u>Employee Health Insurance</u>	<u>4,775</u>	(Indicate # of checks performed <u>105</u> )		
				<u>Employee Meals</u>	<u>24,304</u>	<u>Patient Background Checks</u>	<u>1,165</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Yellow Page Advertising</u>	<u>2,502</u>	
				<u>Chicago Department of Revenue - Head Tax</u>	<u>(364)</u>	<u>Secretary of State Annual Report</u>	<u>100</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>						<u>Costco Memb=110, prior year bal=2290</u>	<u>2,400</u>	
<b>(List each licensed administrator separately.)</b>			\$			<u>MES of Illinois</u>	<u>175</u>	
<b>B. Administrative - Other</b>						<u>Cablelascom Direct Marketing</u>	<u>196</u>	
Description			Amount			<b>Less: Public Relations Expense</b>	( )	
			\$			<u>Non-allowable advertising</u>	<u>(196)</u>	
						<u>Yellow page advertising</u>	<u>(2,502)</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$	<b>TOTAL (agree to Schedule V,</b>	\$ <u>249,086</u>	<b>TOTAL (agree to Sch. V,</b>	\$ <u>6,880</u>	
<b>(Attach a copy of any management service agreement)</b>				<b>line 22, col.8)</b>		<b>line 20, col. 8)</b>		
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>		<b>G. Schedule of Travel and Seminar**</b>		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Bosworth Law Office</u>	<u>Legal</u>		\$ <u>3,813</u>			\$	<u>Out-of-State Travel</u>	\$
<u>Caitlin Deductible Rec. Group</u>	<u>Legal(no copies)</u>		<u>5,000</u>					
<u>Polsinelli, Shugart</u>	<u>Legal</u>		<u>58,976</u>				<u>In-State Travel</u>	
<u>Zoller Swanson &amp; Co.</u>	<u>Accounting</u>		<u>29,820</u>					
<u>Canon Fire Protection</u>	<u>Fire</u>		<u>4,072</u>					
<u>Illinois Fire and Safety</u>	<u>Fire</u>		<u>626</u>					
<u>MDI Archive</u>	<u>Computer</u>		<u>3,109</u>				<u>Seminar Expense</u>	
<u>Caitlin Deductible Rec. Group</u>	<u>Legal</u>		<u>1,766</u>				<u>Michigan Peer Review</u>	<u>2,105</u>
							<u>Real Estate License Course</u>	<u>135</u>
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <u>107,182</u>	<b>TOTAL</b>		\$	<b>Entertainment Expense</b>	( )
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>							(agree to Sch. V,	
							<b>line 24, col. 8)</b>	\$ <u>2,240</u>

\* Attach copy of IMRF notifications

\*\*See instructions.

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

(See instructions.)

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

Facility Name &amp; ID Number Columbus Manor Residential Care Home

# 0007781

Report Period Beginning:

1/1/12

Ending:

12/31/12

**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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A 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. \$ 104,400  
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? N/A
- (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. \$ 24,304 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? No  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
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: \_\_\_\_\_
- (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