FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0037556

Facility Name: Columbia Convalescent Center

Address: 253 Bradington Drive (Number) Columbia (City) 62236 (Zip Code)

County: Monroe

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven C Wolf **Telephone Number:** 618-234-2273
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Steven C. Wolf
(Title) Owner

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,061	1,131	2,488	4,680	8
9	SNF/PED					9
10	ICF	16,215	18,167		34,382	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,276	19,298	2,488	39,062	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.93%

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 [X]

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

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 2,488

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	268,390	22,153	9,530	300,073		300,073		300,073			1
2	Food Purchase		206,764		206,764		206,764	(5,620)	201,144			2
3	Housekeeping	192,794	18,583	44	211,421		211,421		211,421			3
4	Laundry	101,171	15,304	6,198	122,673		122,673		122,673			4
5	Heat and Other Utilities			164,779	164,779		164,779		164,779			5
6	Maintenance	94,540	23,327	27,363	145,230		145,230		145,230			6
7	Other (specify):*											7
8	TOTAL General Services	656,895	286,131	207,914	1,150,940		1,150,940	(5,620)	1,145,320			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,396,323	97,306	273,447	2,767,076	(217,598)	2,549,478		2,549,478			10
10a	Therapy					217,598	217,598		217,598			10a
11	Activities	93,244	10,638		103,882	1,309	105,191		105,191			11
12	Social Services	41,593	259	2,617	44,469	(1,309)	43,160		43,160			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,531,160	108,203	300,064	2,939,427		2,939,427		2,939,427			16
	C. General Administration											
17	Administrative	113,850		114,756	228,606		228,606		228,606			17
18	Directors Fees											18
19	Professional Services			107,964	107,964		107,964	780	108,744			19
20	Dues, Fees, Subscriptions & Promotions			19,732	19,732		19,732	(6,175)	13,557			20
21	Clerical & General Office Expenses	180,671	6,533	82,594	269,798		269,798		269,798			21
22	Employee Benefits & Payroll Taxes			557,315	557,315		557,315		557,315			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,832	9,832		9,832		9,832			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			101,048	101,048		101,048	(23,460)	77,588			26
27	Other (specify):* cable tv			7,300	7,300		7,300	(7,300)				27
28	TOTAL General Administration	294,521	6,533	1,000,541	1,301,595		1,301,595	(36,155)	1,265,440			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,482,576	400,867	1,508,519	5,391,962		5,391,962	(41,775)	5,350,187			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: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			181,748	181,748		181,748		181,748			30
31	Amortization of Pre-Op. & Org.			2,760	2,760		2,760		2,760			31
32	Interest			122,478	122,478		122,478	(3,899)	118,579			32
33	Real Estate Taxes			103,430	103,430		103,430		103,430			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			31,799	31,799		31,799		31,799			35
36	Other (specify):*											36
37	**TOTAL Ownership**			442,215	442,215		442,215	(3,899)	438,316			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		95,858		95,858		95,858		95,858			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		4,674		4,674		4,674		4,674			41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):* **taxes**			5,834	5,834		5,834		5,834			43
44	**TOTAL Special Cost Centers**		100,532	70,987	171,519		171,519		171,519			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,482,576	501,399	2,021,721	6,005,696		6,005,696	(45,674)	5,960,022			45

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

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,620)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,300)	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	(3,899)	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	(1,146)	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	(4,954)	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)**	$ (46,454)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 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)	390	19	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 390		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (46,064)		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 Yes	2 No	3 Amount	4 Reference	
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	**TOTAL (C): (sum of lines 38-46)**			$		47

Columbia Convalescent Center

ID# 0037556

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	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	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,620)	0	0	0	0	0	0	0	0	0	0	(5,620)	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**	(5,620)	0	0	0	0	0	0	0	0	0	0	(5,620)	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	390	390	0	0	0	0	0	0	0	0	0	780	19
20	Fees, Subscriptions & Promotions	(6,175)	0	0	0	0	0	0	0	0	0	0	(6,175)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(23,460)	0	0	0	0	0	0	0	0	0	0	(23,460)	26
27	Other (specify):*	(7,300)	0	0	0	0	0	0	0	0	0	0	(7,300)	27
28	**TOTAL General Administration**	(36,545)	390	0	0	0	0	0	0	0	0	0	(36,155)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(42,165)	390	0	0	0	0	0	0	0	0	0	(41,775)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	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)	
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	(3,899)	0	0	0	0	0	0	0	0	0	0	(3,899)	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**	(3,899)	0	0	0	0	0	0	0	0	0	0	(3,899)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(46,064)	390	0	0	0	0	0	0	0	0	0	(45,674)	45

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Wolf	50	Eldercare of Alton/Calvin Johnson Care Center	Alton/ Belleville	Eldercare/SAMAS	Belleville	Mgmt Co
Michael Riley	16			SAMAS	Belleville	Mgmt Co
Minority shareholders	34					

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 114,756	SAMAS PARTNERSHIP	0.00%	$ 114,756	$	1
2	V								2
3	V	19	Accounting fees		SAMAS PARTNERSHIP	0.00%	390	390	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			$ 114,756			$ 115,146	$ * 390	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: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Wolf	President	Owner/Admin	50.00	248,248	10	14.00	Mgmt Fees	$ 38,249	17-3	1
2	Michael Riley	Secretary	Owner/Admin	16.00	0	20	30.00	Mgmt Fees	38,260	17-3	2
3	Steven Brant	Treasurer	Owner/Admin	4.00	0	24	35.00	Mgmt Fees	38,247	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 114,756		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: 01/01/2010 Ending: 2/31/2010

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 [X]

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

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	The Bank of Edwardsville		X	Renovation	$1,880.00	6/2/2007	200,000	158,601	12/2/2010	6.6250	9,073	2
3	The Bank of Edwardsville		X	Mortgage	$20,608.61	12/22/05	2,636,000	1,979,313	8/11/2019	6.1250	112,422	3
4												4
5												5
	Working Capital											
6												6
7	The Bank of Edwardsville		X	Working Capital	interest only	12/15/06	500,000		12/15/10	Variable	983	7
8												8
9	TOTAL Facility Related				$22,488.61		$ 3,336,000	$ 2,137,914			$ 122,478	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,336,000	$ 2,137,914			$ 122,478	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.)**

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 88,115	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.)		$ 95,773	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,658	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 95,772	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 103,430	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	67,625	8
2006	70,364	9
2007	82,303	10
2008	86,388	11
2009	95,773	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Columbia Convalescent Center COUNTY Monroe

FACILITY IDPH LICENSE NUMBER 0037556

CONTACT PERSON REGARDING THIS REPORT Steve Wolf

TELEPHONE 618-234-2273 FAX #: 618-234-7777

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-17-481-028-000	Lot 2 & Pt Lot 1 Bradington Pl	$ 25,389.50	$ 25,389.50
2.	04-17-481-005-000	Part Lot 4 Sur 416	$ 692.78	$ 692.78
3.	04-17-481-004-000	Part Lot 4 Sur 416	$ 69,690.72	$ 69,690.72
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 95,773.00	$ 95,773.00

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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? [X] (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? [X] (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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1991	1991	$ 2,115,587	$ 52,890	40	$ 52,890	$	$ 1,057,794	4
5			1991	1991	48,503		15			47,695	5
6	20		1998	1998	1,170,228	29,256	40	29,256		363,258	6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1991	147,905	7,395	20	7,395		141,126	9
10	Fixed Equipment			1991	24,679		15			24,679	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			1,430	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		1,297	17
18	Cold Water Line			1996	6,803	174	39	174		2,558	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		1,424	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		501	28
29	Fan			1997	1,083	28	39	28		365	29
30	Landscaping			1998	4,030	269	15	269		3,265	30
31	Landscaping			1998	7,429	495	15	495		6,150	31
32	Irrigation System			1998	12,990	866	15	866		10,753	32
33	Parking Lot			1998	15,912	1,061	15	1,061		13,172	33
34	Landscaping			1998	10,479	699	15	699		8,674	34
35	Sidewalks			1998	19,864	1,324	15	1,324		16,443	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	Flooring & Carpeting	1998	$ 36,840	$	10	$	$	$ 36,840	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		5,283	47
48	Water Heater Replacement	1999	35,258		10			35,258	48
49	Washer & Dryer	1999	4,600		10			4,600	49
50	Air Conditioner	1999	8,965		10			8,965	50
51	Room Renovations	1999	6,778		5-10y			6,778	51
52	Door Security System	1999	14,347		10			14,347	52
53	Landscaping	2000	1,987	132	15	132		1,368	53
54	Water Heater Replacement	2000	6,848	57	10	57		6,848	54
55	Carpeting	2000	1,579	79	10	79		1,579	55
56	Floor Tile	2001	1,546	155	10	155		1,533	56
57	Landscaping	2001	2,127	142	15	142		1,363	57
58	Evaporator Coil	2001	2,514	251	10	251		2,409	58
59	Vinal Trim Window	2001	6,459	646	10	646		5,921	59
60	Painting	2001	6,080	608	10	608		5,523	60
61	Telephone System	2001	1,631		5			1,631	61
62	Alert System	2001	6,443		7			6,443	62
63	Alert System	2002	6,442		7			6,442	63
64	Landscaping	2002	417	28	15	28		243	64
65	Heating Cooling	2002	7,477	748	10	748		6,419	65
66	Carpeting, fire doors, electrical	2002	4,968	497	10	497		4,159	66
67	Parking Lot	2003	3,420	228	15	228		1,615	67
68	Hot Water Heater	2002	2,380	238	10	238		2,122	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,924,076	$ 98,962		$ 98,962	$	$ 2,024,424	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12A, Carried Forward		$ 3,924,076	$ 98,962		$ 98,962	$	$ 2,024,424	1
2	Bathroom impr	2003	624	62	10	62		453	2
3	Air Conditioning/temp control	2003	3,604	360	10	360		2,612	3
4	Nurse Call System	2003	1,075	107	10	107		770	4
5	Hot water system	2003	5,603	560	10	560		4,296	5
6	Payroll wiring/ time system	2003	2,000	200	10	200		1,567	6
7	Valves,adapters, coils A/C	2003	3,626	363	10	363		2,776	7
8	Security upgrades	2003	522	52	10	52		396	8
9	Control joints	2003	1,019	102	10	102		781	9
10	Parking lot sealer/striping	2004	300	20	15	20		138	10
11	Guard rails, concrete work docking area	2004	17,387	1,159	15	1,159		7,011	11
12	New Lighting	2004	21,784	2,178	10	2,178		13,844	12
13	Painting	2004	2,115	211	10	211		1,354	13
14	Air Conditioning/Hot water system	2004	8,069	807	10	807		5,553	14
15	Wiring call system, security system	2004	2,917	292	10	292		1,961	15
16	Flooring	2004	1,777	178	10	178		1,140	16
17	Kitchen Hood, grill	2004	2,871	287	10	287		1,760	17
18	Fire dampers	2004	2,600	260	10	260		1,560	18
19	Generator tank	2004	3,632	363	10	363		2,482	19
20	Plumbing	2004	974	97	10	97		666	20
21	Ventilation Laundry dept	2004	15,505	1,551	10	1,551		10,208	21
22	Thermocouplers	2004	1,208	121	10	121		836	22
23	Awnings	2005	2,210	221	10	221		1,225	23
24	Doors	2005	3,981	398	10	398		2,289	24
25	Plumbing and filter system	2005	9,949	995	10	995		5,804	25
26	Underground piping	2005	1,885	188	10	188		990	26
27	Handrails	2005	4,518	452	10	452		2,334	27
28	Landscaping	2005	1,300	87	15	87		448	28
29	Doors and kickplates	2006	1,438	144	10	144		608	29
30	Plumbing,water conditioners, heaters	2006	20,427	2,354	10	2,354		10,813	30
31	Air conditioning	2006	7,979	798	10	798		3,391	31
32	cubicle curtains	2006	294	42	7	42		185	32
33	sidewalk and landscaping	2006	9,320	621	15	621		2,589	33
34	TOTAL (lines 1 thru 33)		$ 4,086,589	$ 114,592		$ 114,592	$	$ 2,117,264	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 4,086,589	$ 114,592		$ 114,592	$	$ 2,117,264	1
2	Sidewalk	2007	2,700	180	15	180		705	2
3	Landscaping	2007	400	40	10	40		150	3
4	New flooring	2007	13,998	1,400	10	1,400		4,783	4
5	Laundry	2007	12,461	1,246	10	1,246		4,777	5
6	Fireproofing	2007	10,250	1,025	10	1,025		3,387	6
7	Paint, drywall, molding, panels	2007	35,163	3,516	10	3,516		11,865	7
8	lighting fixtures	2007	23,181	2,318	10	2,318		8,106	8
9	water lines, heater	2007	10,307	1,031	10	1,031		3,146	9
10	cabinets,cable,cubicle,hand rails	2007	2,640	264	10	264		854	10
11	fiberglass panels	2007	2,520	252	10	252		840	11
12	mulch,shrubs,parking lot	2008	7,751	775	10	775		1,971	12
13	heating/AC	2008	19,554	1,955	10	1,955		4,717	13
14	window treatments	2008	13,410	1,341	10	1,341		3,814	14
15	flooring	2008	27,542	2,754	10	2,754		7,379	15
16	valves and piping	2008	10,571	1,057	10	1,057		2,729	16
17	paint chapel,dining room,nurse station	2008	2,470	247	10	247		617	17
18	counters, door closers regulator	2008	2,212	221	10	221		457	18
19	Curbing/bushes	2009	1,286	129	10	129		204	19
20	Flooring	2009	6,898	690	10	690		1,191	20
21	HVAC	2009	19,363	1,936	10	1,936		2,951	21
22	Drop Ceiling	2009	1,180	118	10	118		216	22
23	Electrical boxes	2009	1,022	102	10	102		179	23
24	Emergency electrical backup/wiring	2009	3,558	356	10	356		593	24
25	Bathroom remodeling	2009	3,401	340	10	340		567	25
26	Windows	2009	891	89	10	89		111	26
27	Installed new phone system	2009	16,847	1,685	10	1,685		2,667	27
28	A/C coil/exhaust	2010	6,693	238	10	238		238	28
29	annoucement speakers,wiring	2010	2,132	107	10	107		107	29
30	sprinkler heads	2010	1,380	92	10	92		92	30
31	Roofing	2010	2,180	42	39	42		42	31
32	Windows replaced	2010	2,987	48	39	48		48	32
33	parking lot and irrigation lines moved	2010	5,761	240	10	240		240	33
34	TOTAL (lines 1 thru 33)		$ 4,359,298	$ 140,426		$ 140,426	$	$ 2,187,007	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: 01/01/2010 Ending: 12/31/2010

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	$ 411,975	$ 40,745	$ 40,745	$	5-10	$ 212,565	71
72	Current Year Purchases	16,938	540	540		10	540	72
73	Fully Depreciated Assets	581,220					581,220	73
74								74
75	TOTALS	$ 1,010,133	$ 41,285	$ 41,285	$		$ 794,325	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	Facility	tires for van	2010	1,109	37	37		5	37	77
78										78
79										79
80	TOTALS			$ 39,323	$ 37	$ 37	$		$ 38,251	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)	$ 5,686,338	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 181,748	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 181,748	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)	$ 3,019,583	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 31,799 Description: office-4459/dietary-799/nursing-21982/laundry-4559
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	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	$	1,363	$ 94,230	$	1,363	$ 94,230	1
2	Licensed Speech and Language Development Therapist	10-A-3	hrs		315	24,185		315	24,185	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-A-3	hrs		1,665	98,502	570	1,665	99,072	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				89,573		89,573	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab/x-ray	39-2					6,285		6,285	12
13	Other (specify):									13
14	TOTAL			$	3,343	$ 216,917	$ 96,428	3,343	$ 313,345	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.

STATE OF ILLINOIS

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 19,803	$	1
2	Cash-Patient Deposits	16,191		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	356,865		3
4	Supply Inventory (priced at cost)	30,789		4
5	Short-Term Investments			5
6	Prepaid Insurance	86,808		6
7	Other Prepaid Expenses	3,372		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from employees			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 513,828	$	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	4,359,295		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,049,459		16
17	Accumulated Depreciation (book methods)	(3,019,583)		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): unamortized fin fees	6,350		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,673,105	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,186,933	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 165,896	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,191		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,642		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,326		31
32	Accrued Real Estate Taxes(Sch.IX-B)	95,772		32
33	Accrued Interest Payable	8,493		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accrued mgmt fees	16,656		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 416,976	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	158,601		39
40	Mortgage Payable	1,979,313		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)**	$ 2,137,914	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,554,890	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 632,043	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,186,933	$	48

*(See instructions.)

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 659,760	1
2	Restatements (describe):		2
3			3
4	**Prior Period Adjustment**	20,000	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 679,760	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	182,283	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	(230,000)	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)**	$ (47,717)	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)**	$ 632,043	24 *

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

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,586,280	1
2	Discounts and Allowances for all Levels	33,545	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,619,825	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	415,593	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 415,593	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	5,620	14
15	Telephone, Television and Radio	7,311	15
16	Rental of Facility Space		16
17	Sale of Drugs	76,873	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,567	19
20	Radiology and X-Ray	1,910	20
21	Other Medical Services	25,477	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 137,558	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,899	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,899	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	vending	7,388	28
28a	misc income	3,716	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,104	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,187,979	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,150,940	31
32	Health Care	2,939,427	32
33	General Administration	1,301,595	33
	B. Capital Expense		
34	Ownership	442,215	34
	C. Ancillary Expense		
35	Special Cost Centers	106,366	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,005,696	40
41	**Income before Income Taxes (line 30 minus line 40)****	182,283	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 182,283	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: 01/01/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,066	2,254	$ 78,604	$ 34.87	1
2	Assistant Director of Nursing	1,927	2,088	65,516	31.38	2
3	Registered Nurses	11,207	12,103	343,758	28.40	3
4	Licensed Practical Nurses	29,817	32,558	665,570	20.44	4
5	CNAs & Orderlies	92,371	100,640	1,175,472	11.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,673	4,150	67,402	16.24	8
9	Activity Director	1,758	2,016	30,761	15.26	9
10	Activity Assistants	6,494	7,052	62,483	8.86	10
11	Social Service Workers	2,428	2,731	41,593	15.23	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,209	2,447	37,060	15.15	14
15	Cook Helpers/Assistants	6,103	6,722	82,791	12.32	15
16	Dishwashers	15,340	16,765	148,539	8.86	16
17	Maintenance Workers	6,002	6,392	94,540	14.79	17
18	Housekeepers	19,238	21,233	192,794	9.08	18
19	Laundry	10,381	11,266	101,171	8.98	19
20	Administrator	2,418	2,533	113,850	44.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,193	12,914	180,671	13.99	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)	225,625	245,864	$ 3,482,575 *	$ 14.16	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	211	$ 9,078	1-3	35
36	Medical Director	monthly fee	24,000	9-3	36
37	Medical Records Consultant	17	959	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly fee	6,506	10-3	39
40	Physical Therapy Consultant	246	14,773	10-3	40
41	Occupational Therapy Consultant	117	5,204	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	1,387	10-3	43
44	Activity Consultant	25	1,309	11-5	44
45	Social Service Consultant	25	1,309	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	661	$ 64,525		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	132	4,353	10-3	51
52	Certified Nurse Assistants/Aides	892	17,671	10-3	52
53	TOTAL (lines 50 - 52)	1,024	$ 22,024		53

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Hope McNitt	Administrator	0	$ 113,850
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 113,850

B. Administrative - Other

Description	Amount
SAMAS Management Fees	$ 114,756
TOTAL (agree to Schedule V, line 17, col. 3)	$ 114,756
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
J W Boyle	Accounting	$ 26,061
Wessell & Sherman	Legal	2,140
Elvidge Kelley	Legal	125
Greensfelder, Hemke	Legal	64,231
Flymm & Guymon	Legal	5,550
Dwayne Morris	Legal	9,857
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 107,964

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 127,899
Unemployment Compensation Insurance	24,949
FICA Taxes	259,909
Employee Health Insurance	116,766
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 K	5,208
other benefits	22,584
TOTAL (agree to Schedule V, line 22, col.8)	$ 557,315

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
	N/A	
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	7,400
Health Care Worker Background Check	2,803
(Indicate # of checks performed)	
Patient Background Checks	
Licenses and fees	2,359
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,557

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,969
Seminar Expense	6,863
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,832

**See instructions.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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						N/A							
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Columbia Convalescent Center **#** 0037556 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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. $ **65,153**
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. $ **5,620**

(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.