

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
ANNUAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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.

<p>I. IDPH License ID Number: <u>0052407</u></p> <p>Facility Name: <u>Columbus Manor Res Care Home</u></p> <p>Address: <u>5107-21 W Jackson Bl</u> <u>Chicago</u> <u>60644</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>773-378-5490</u> Fax # (<u>7733787860</u>)</p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>08/19/2013</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Manoj Baby</u> Telephone Number: <u>773-378-5490</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2014</u> to <u>12/31/14</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ <u>05/08/2015</u> (Date)</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>AFZAL LOKHANDWALA</u></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>PRESIDENT</u></td> </tr> <tr> <td style="border: none;">Paid Preparer</td> <td style="border: none;">(Signed) _____ (Date)</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name & Address) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) (_____) Fax # (_____)</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ <u>05/08/2015</u> (Date)		(Type or Print Name) <u>AFZAL LOKHANDWALA</u>		(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) _____ (Date)		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) (_____) Fax # (_____)
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____																
Officer or Administrator of Provider	(Signed) _____ <u>05/08/2015</u> (Date)																	
	(Type or Print Name) <u>AFZAL LOKHANDWALA</u>																	
	(Title) <u>PRESIDENT</u>																	
Paid Preparer	(Signed) _____ (Date)																	
	(Print Name and Title) _____																	
	(Firm Name & Address) _____																	
	(Telephone) (_____) Fax # (_____)																	

Facility Name & ID Number Columbus Manor Res Care Home

0052407 Report Period Beginning: 01/01/2014 Ending: 12/31/14

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 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF	49,898	0	0	49,898	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,898			49,898	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.33%

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

N/A (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)

N/A

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 08/19/13

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

YES Date 08/19/13 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 _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number

Columbus Manor Res Care Home

0052407

Report Period Beginning:

01/01/2014

Ending:

12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	197,063	8,889		205,952		205,952	0	205,952		1
2	Food Purchase		365,963		365,963		365,963	0	365,963		2
3	Housekeeping	128,367			128,367		128,367	0	128,367		3
4	Laundry			17,058	17,058	0	17,058	0	17,058		4
5	Heat and Other Utilities			159,409	159,409		159,409	0	159,409		5
6	Maintenance	122,335	186,924		309,259		309,259	0	309,259		6
7	Other (specify):* Security	193,767	4,036		197,803		197,803	0	197,803		7
8	TOTAL General Services	641,532	565,812	176,467	1,383,811	0	1,383,811	0	1,383,811		8
	B. Health Care and Programs										
9	Medical Director				0		0	0	0		9
10	Nursing and Medical Records	1,001,836	2,653	10,900	1,015,389		1,015,389	0	1,015,389		10
10a	Therapy				0		0	0	0		10a
11	Activities	82,042	73,330		155,372		155,372	0	155,372		11
12	Social Services	183,046			183,046		183,046	0	183,046		12
13	CNA Training				0		0	0	0		13
14	Program Transportation				0		0	0	0		14
15	Other (specify):*				0		0	0	0		15
16	TOTAL Health Care and Programs	1,266,924	75,983	10,900	1,353,807	0	1,353,807	0	1,353,807		16
	C. General Administration										
17	Administrative	133,954	55,960	40,069	229,983		229,983	0	229,983		17
18	Directors Fees				0		0	0	0		18
19	Professional Services			36,833	36,833		36,833	0	36,833		19
20	Dues, Fees, Subscriptions & Promotions				0		0	0	0		20
21	Clerical & General Office Expense:				0		0	0	0		21
22	Employee Benefits & Payroll Tax:			3,999	3,999		3,999	0	3,999		22
23	Inservice Training & Educatior				0		0	0	0		23
24	Travel and Seminar				0		0	0	0		24
25	Other Admin. Staff Transportator				0		0	0	0		25
26	Insurance-Prop.Liab.Malpractice			143,083	143,083		143,083	0	143,083		26
27	Other (specify):* RENT				0		0	0	0		27
28	TOTAL General Administration	133,954	55,960	223,984	413,898	0	413,898	0	413,898		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,042,410	697,755	411,351	3,151,516	0	3,151,516	0	3,151,516		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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			67,886	67,886		67,886	0	67,886		30
31	Amortization of Pre-Op. & Org.				0		0	0	0		31
32	Interest				0		0	0	0		32
33	Real Estate Taxes			103,280	103,280		103,280	0	103,280		33
34	Rent-Facility & Grounds			180,000	180,000		180,000	0	180,000		34
35	Rent-Equipment & Vehicles				0		0	0	0		35
36	Other (specify):*				0		0	0	0		36
37	TOTAL Ownership			351,166	351,166	0	351,166	0	351,166		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportator				0		0	0	0		38
39	Ancillary Service Centers				0		0	0	0		39
40	Barber and Beauty Shops				0		0	0	0		40
41	Coffee and Gift Shop:				0		0	0	0		41
42	Provider Participation Fee				0		0	0	0		42
43	Other (specify):*				0		0	0	0		43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,042,410	697,755	762,517	3,502,682	0	3,502,682	0	3,502,682		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 Columbus Manor Res Care Home

0052407

Report Period Beginning: 01/01/2014

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room:				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 & Refund:				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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer:				22
23	Malpractice Insurance for Individual:				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employee:				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 0		\$ 0	30

BHF USE ONLY					
48		49		50	
					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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 0		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 0		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport			\$		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

Columbus Manor Res Care Home

Report Period Beginning: ID# 0052407
 Ending: 01/01/2014
 12/31/14

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 Columbus Manor Res Care Home

0052407

Report Period Beginning:

01/01/2014

Ending:

12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxe	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Educator	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 Transportator	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Columbus Manor Res Care Home

0052407

Report Period Beginning:

01/01/2014 Ending:

12/31/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportator	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 Shop:	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)	0	0	0	0	0	0	0	0	0	0	0	0	45

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
SHAHID YUSUF	23.33			ZSS HOLDINGS	CHICAGO	S-CORP
AMIN RAZZAK	3.25					
SYEDA SHEIKH	33.34					
AFZAL LOKHANDWALA	33.33					
SAAD YUSUF	6.75					

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	RENT	\$ 180,000	ZSS HOLDINGS	0.00%	\$	\$	(180,000) 1
2	V							2
3	V							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		\$ 180,000			\$	\$ *	(180,000) 14

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

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 Res Care Home # 0052407 Report Period Beginning: 01/01/2014 Ending: 12/31/14

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	SHAHID YUSUF	SECRETARY		23.33	0	1	2.50	SALARY	\$ 1,615	17-1	1
2	AFZAL LOKHANDWALA	PRESIDENT		33.33	0	5	12.50	SALARY	1,615	17-1	2
3	Dr. TAHIR SHEIKH	Medical Director			0	1	2.50	SALARY	1,615	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,845		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 Res Care Home

0052407 Report Period Beginning: 01/01/2014 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

Columbus Manor Res Care Home

0052407

Report Period Beginning:

01/01/2014

Ending:

12/31/14

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**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1							\$	\$			\$	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	ZSS Holding Company	x		Operating	\$15,000.00	9/28/2013	900,000	38,125	9/1/2018	5.0000	0	6					
7												7					
8												8					
9	TOTAL Facility Related				\$15,000.00		\$ 900,000	\$ 38,125			\$ 0	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$ 0	\$ 0			\$ 0	14					
15	TOTALS (line 9+line14)						\$ 900,000	\$ 38,125			\$ 0	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2013 report.	\$			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.)	\$	103,280		2
3.	Under or (over) accrual (line 2 minus line 1).	\$	103,280		3
4.	Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			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	\$	103,280		7
Real Estate Tax History					
Real Estate Tax Bill for Calendar Year		2009	_____	8	
		2010	_____	9	
		2011	_____	10	
		2012	_____	11	
		2013	_____	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2013 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.**

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).

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>BUILDING SITE</u>	<u>41,988</u>	<u>2013</u>	<u>\$ 60,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	41,988		\$ 60,000	3

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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	HEATING EQUIPMENT		2013	7,685	5,333	7	2,070	(3,263)	5,333	9
10	FENCING		2013	19,740	10,857	7	2,820	(8,037)	10,857	10
11	SURVEILLANCE SYSTEM		2013	14,500	11,020	15	1,933	(9,087)	11,020	11
12	CABLE BOXES		2013	1,132	860	5	453	(407)	860	12
13	2013 BUILDING IMPROVEMENTS		2013	9,500	950	15	1,267	317	950	13
14	2014 LEASEHOLD IMPROVEMENTS		2014	15,622	200	39	400	200	200	14
15	2014 FURNITURE AND FIXTURES		2014	12,538	12,538	7	1,791	(10,747)	12,538	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

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Columbus Manor Res Care Home

0052407

Report Period Beginning:

01/01/2014 Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	80,717	\$	41,758	\$	10,734	\$	(31,024)	\$	41,758	70

**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	\$ 263,976	\$ 62,936	\$ 37,711	\$ (25,225)	7	\$ 106,636	71
72	Current Year Purchases	42,610	42,610	6,087	(36,523)	7	42,610	72
73	Fully Depreciated Assets	42,610	42,610		(42,610)	7	42,610	73
74					0			74
75	TOTALS	\$ 349,196	\$ 148,156	\$ 43,798	\$ (104,358)		\$ 191,856	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				\$	\$	\$	0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	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)	\$ 489,913	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 189,914	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 54,532	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (135,382)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 233,614	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

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.	<u>/2015</u>	\$ _____
13.	<u>/2016</u>	\$ _____
14.	<u>/2017</u>	\$ _____

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

* 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?</p> <p><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			Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$	\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			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	TOTAL			\$		\$		\$		\$		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.

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

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 227,861	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced a)			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	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 227,861	\$ 0	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cos			14
15	Leasehold Improvements, at Historical Cos	68,179		15
16	Equipment, at Historical Cos	309,086		16
17	Accumulated Depreciation (book methods)	43,798		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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 421,063	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 648,924	\$ 0	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 66,808	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	6,927		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	12,810		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 86,545	\$ 0	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	284,720		39
40	Mortgage Payable			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)	\$ 284,720	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 371,265	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (16,004)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 355,261	\$ 0	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (408,656)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (408,656)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	392,652	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:	()	13
14	Donated Property, Plant, and Equipmen		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 392,652	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (16,004)	24 *

* 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		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 3,853,920	1	
2	Discounts and Allowances for all Level	(26,798)	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,827,122	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy		6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 0	8	
C. Other Operating Revenue				
9	Payments for Educator		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 Radic		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	326	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 326	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28			28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 0	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,827,448	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,383,811	31	
32	Health Care	1,353,807	32	
33	General Administration	413,898	33	
B. Capital Expense				
34	Ownership		34	
C. Ancillary Expense				
35	Special Cost Centers		35	
36	Provider Participation Fee		36	
D. Other Expenses (specify):				
37	RENT	180,000	37	
38	PROPERTY TAX	103,280	38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,434,796	40	
41	Income before Income Taxes (line 30 minus line 40)**	392,652	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 392,652	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	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 0	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 Res Care Home

0052407

Report Period Beginning:

01/01/2014

Ending:

12/31/14

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	1,554	1,554	\$ 50,357	\$ 32.40	1
2	Assistant Director of Nursing	1,615	1,615	39,748	24.61	2
3	Registered Nurses	3,077	3,077	87,124	28.31	3
4	Licensed Practical Nurses	16,286	16,286	365,601	22.45	4
5	CNAs & Orderlies	33,423	33,423	303,438	9.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,078	2,078	29,411	14.15	9
10	Activity Assistants	3,973	3,973	49,305	12.41	10
11	Social Service Workers	8,996	8,996	159,355	17.71	11
12	Dietician					12
13	Food Service Supervisor	2,069	2,069	41,375	20.00	13
14	Head Cook	1,838	1,838	23,086	12.56	14
15	Cook Helpers/Assistants	5,703	5,703	69,486	12.18	15
16	Dishwashers	4,445	4,445	41,736	9.39	16
17	Maintenance Workers	7,885	7,885	110,383	14.00	17
18	Housekeepers	10,492	10,492	97,301	9.27	18
19	Laundry	2,073	2,073	20,012	9.65	19
20	Administrator	2,160	2,160	65,933	30.52	20
21	Assistant Administrator	2,077	2,077	54,002	26.00	21
22	Other Administrative	720	720	4,500	6.25	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	1,521	1,521	18,903	12.43	31
32	Other Health Care(specify)					32
33	Other(specify) <u>SECURITY</u>	18,868	18,868	201,597	10.68	33
34	TOTAL (lines 1 - 33)	130,853	130,853	\$ 1,832,653 *	\$ 14.01	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	\$		35
36	Medical Director			36
37	Medical Records Consultant			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			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		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				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
AFZAL LOKHANDWALA	PRESIDENT	33.33	\$ 1,615	Workers' Compensation Insurance	\$	IDPH License Fee	\$		
TAHIR SHEIKH	OWNER	0	1,615	Unemployment Compensation Insurance		Advertising: Employee Recruitment			
SHAHID YUSUF	SECRETARY	23.33	1,615	FICA Taxes		Health Care Worker Background Check			
MANOJ BABY	Asst. Administrator	0	58,133	Employee Health Insurance		(Indicate # of checks performed _____)			
NERAD PERSADSIGH	Administrator	0	70,976	Employee Meals		<u>Patient Background Checks</u>			
				Illinois Municipal Retirement Fund (IMRF)*					
				<u>EMPLOYEE BONUS</u>	<u>3,999</u>				
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 133,954						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
	\$					\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 3,999	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
PRM LTD	ACCOUNTING	\$ 14,200				\$	Out-of-State Travel	\$	
LEGAT ARCHITECTS	PROFESSIONAL	6,350					In-State Travel		
EUGEN GRIFFIN	LEGAL	10,248					Seminar Expense		
STOUT RISIUS ROSS	LEGAL	6,035					Entertainment Expense	()	
							TOTAL (agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	TOTAL	
(For legal fee disclosure, see page 39 of instructions)			\$ 36,833						

* 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	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	TOTALS	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Columbus Manor Res Care Home

0052407

Report Period Beginning: 01/01/2014 Ending: 12/31/14

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
If YES, give association name and amount NO
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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
What was the average life used for new equipment added during this period YES
7
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. : 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedure consistent with prior reports? N/A 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. \$ 0
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 for an individual employee? X 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? NO 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 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? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
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. \$ _____
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details YES
Attach invoices and a summary of services for all architect and appraisal fees _____