

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: <u>0049510</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>COLONIAL HALL CARE CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/11</u> to <u>12/31/11</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>515 BUREAU VALLEY PARKWAY</u> <u>PRINCETON</u> <u>61356</u>																									
Number City Zip Code																									
County: <u>BUREAU</u>																									
Telephone Number: <u>(815) 875-3347</u> Fax # <u>(815) 875-2012</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>DARRYL BUEKER, CPA</u> <u>PARTNER</u></td></tr><tr><td>(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u></td></tr><tr><td>(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>DARRYL BUEKER, CPA</u> <u>PARTNER</u>	(Firm Name & Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u>	(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>	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												
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Date of Initial License for Current Owners: <u>5/1/07</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>DARRYL BUEKER</u> Telephone Number: <u>(417) 865-8701</u>																									
Email Address: _____																									

Facility Name & ID Number COLONIAL HALL CARE CENTER

0049510 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	88	Skilled (SNF)	88	32,120	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,839		5,055	20,894	8
9	SNF/PED					9
10	ICF		8,382		8,382	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,839	8,382	5,055	29,276	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.15%

D. How many bed-hold days during this year were paid by the Department? NONE (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 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 5/1/07

J. Was the facility purchased or leased after January 1, 1978? YES X Date 5/1/07 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 88 and days of care provided 4,292

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number		COLONIAL HALL CARE CENTER				# 0049510		Report Period Beginning:		1/1/11		Ending: Page 3 12/31/11	
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	219,840	6,283	10,316	236,439		236,439		236,439			1	
2	Food Purchase		157,904		157,904		157,904	(9,235)	148,669			2	
3	Housekeeping	97,708	17,975		115,683		115,683		115,683			3	
4	Laundry	54,676	20,894		75,570		75,570		75,570			4	
5	Heat and Other Utilities			108,044	108,044		108,044	1,616	109,660			5	
6	Maintenance	58,416		69,143	127,559		127,559	2,376	129,935			6	
7	Other (specify):*											7	
8	TOTAL General Services	430,640	203,056	187,503	821,199		821,199	(5,243)	815,956			8	
	B. Health Care and Programs												
9	Medical Director			4,500	4,500		4,500		4,500			9	
10	Nursing and Medical Records	1,617,648	78,617	7,919	1,704,184		1,704,184		1,704,184			10	
10a	Therapy	397,944	25,900	130,950	554,794		554,794		554,794			10a	
11	Activities	63,188	8,100	7,534	78,822		78,822	(41)	78,781			11	
12	Social Services	42,982		504	43,486		43,486		43,486			12	
13	CNA Training											13	
14	Program Transportation											14	
15	Other (specify):*											15	
16	TOTAL Health Care and Programs	2,121,762	112,617	151,407	2,385,786		2,385,786	(41)	2,385,745			16	
	C. General Administration												
17	Administrative	97,098		121,455	218,553		218,553	(113,211)	105,342			17	
18	Directors Fees											18	
19	Professional Services			246,183	246,183		246,183	(13,374)	232,809			19	
20	Dues, Fees, Subscriptions & Promotions			62,893	62,893		62,893	(48,125)	14,768			20	
21	Clerical & General Office Expenses	106,031	37,942	49,194	193,167		193,167	37,873	231,040			21	
22	Employee Benefits & Payroll Taxes			548,036	548,036		548,036		548,036			22	
23	Inservice Training & Education											23	
24	Travel and Seminar			10,680	10,680		10,680	19	10,699			24	
25	Other Admin. Staff Transportation			37,074	37,074		37,074	2,692	39,766			25	
26	Insurance-Prop.Liab.Malpractice			67,982	67,982		67,982	6,165	74,147			26	
27	Other (specify):*							9,998	9,998			27	
28	TOTAL General Administration	203,129	37,942	1,143,497	1,384,568		1,384,568	(117,963)	1,266,605			28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,755,531	353,615	1,482,407	4,591,553		4,591,553	(123,247)	4,468,306			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			38	38		38	86,622	86,660			30
31	Amortization of Pre-Op. & Org.							122	122			31
32	Interest			70,402	70,402		70,402	123,677	194,079			32
33	Real Estate Taxes			41,656	41,656		41,656	651	42,307			33
34	Rent-Facility & Grounds			292,764	292,764		292,764	(292,764)				34
35	Rent-Equipment & Vehicles			57,209	57,209		57,209	(7,131)	50,078			35
36	Other (specify):*							4,658	4,658			36
37	TOTAL Ownership			462,069	462,069		462,069	(84,165)	377,904			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			167,397	167,397		167,397		167,397			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			215,577	215,577		215,577		215,577			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,755,531	353,615	2,160,053	5,269,199		5,269,199	(207,412)	5,061,787			45

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

VI. ADJUSTMENT DETAIL

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

	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	(9,213)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,921)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	2		13
14	Non-Care Related Interest	(55,501)	32		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	(3,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(46,339)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,498)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,529)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (129,523)		\$	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)	(77,889)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (77,889)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (207,412)		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

STATE OF ILLINOIS

COLONIAL HALL CARE CENTER

Report Period Beginning: ID# 0049510

Ending: 1/1/11

12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	\$ (2,162)	20	1
2	TRANSPORTATION INCOME	(41)	11	2
3	MISCELLANEOUS INCOME	(7,700)	35	3
4	TAXES - GENERAL	(535)	21	4
5	ADJUST S/L DEPR	2,909	30	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(7,529)		49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

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
		SEE PG6-SUPP				

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	\$ 292,764	PHCH REALTY, LLC		\$	(292,764)	1
2	V	30	DEPRECIATION				82,077	82,077	2
3	V	32	INTEREST				182,073	182,073	3
4	V	36	AMORTIZATION-LOAN COSTS				4,658	4,658	4
5	V	26	INSURANCE				6,764	6,764	5
6	V	19	ACCOUNTING				12,500	12,500	6
7	V								7
8	V	19	PROFESSIONAL FEES	125,590	PHC CONSULTANTS, LLC		97,050	(28,540)	8
9	V								9
10	V	19	PROFESSIONAL FEES	3,755	MTS CONSULTING		3,755		10
11	V								11
12	V								12
13	V								13
14	Total			\$ 422,109			\$ 388,877	\$ * (33,232)	14

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

VII. RELATED PARTIES (continued)

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	HOME OFFICE	\$ 121,455	PLATINUM HEALTH CARE, LLC	100.00%	\$	\$ (121,455)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		1,616	1,616	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		2,376	2,376	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		8,244	8,244	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		2,666	2,666	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		376	376	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		41,222	41,222	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		4,184	4,184	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		19	19	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		2,692	2,692	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		(599)	(599)	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		9,998	9,998	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,021	1,021	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		569	569	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		122	122	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		615	615	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		1,026	1,026	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		651	651	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 121,455			\$ 76,798	\$ * (44,657)	39

* 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	BEN KLEIN	4.34	ALL FAITH PAVILION	CHICAGO	PLATINUM HEALTH	SKOKIE, IL	MANAGEMENT	1
2	BEREKE TRUST	51.5	BELLA VISTA CARE CENTER	PEORIA HEIGHTS	CARE, LLC			2
3	BRIAN LEVINSON	30.83	CAPITOL CARE CENTER	SPRINGFIELD	PHCH REALTY, LLC		BUILDING	3
4	MARK SHAPIRO	13.33	MORTON TERRACE CARE CENTER	MORTON	PHC CONSULTANTS	SKOKIE	CONSULTING	4
5			MORTON VILLA CARE CENTER	MORTON	MTS CONSULTING	SKOKIE	CONSULTING	5
6			RIVER VALLEY SUPPORTING LVG RES	KANKAKEE				6
7			RIVERSHORES CARE CENTER	MARSEILLES				7
8			WOOD GLEN PAVILION	WEST CHICAGO				8
9								9
10								10
11								11
12								12
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30								30

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	BEN KLEIN		Administrative	4.34	SEE ATTACHED	1	3.45	Mgt Fees	\$		1
2	BRIAN LEVINSON		Administrative	30.83	SEE ATTACHED	4	10.00	Mgt Fees			2
3	MARK SHAPIRO		Administrative	13.33	SEE ATTACHED	4	10.00	Mgt Fees			3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 PLATINUM HEALTH CARE, LLC
Street Address 7444 LONG AVENUE
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 329-4100
Fax Number (847) 329-7652

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Patient Days	876,273	29	\$ 48,379	\$	29,276	\$ 1,616	1
2	6	Repairs & Maintenance	Patient Days	876,273	29	71,131		29,276	2,376	2
3	17	Administrative Salary	Patient Days	876,273	29	246,751	246,751	29,276	8,244	3
4	19	Professional Fees	Patient Days	876,273	29	79,792		29,276	2,666	4
5	20	Fees, Subscriptions	Patient Days	876,273	29	11,255		29,276	376	5
6	21	Clerical Salaries	Patient Days	876,273	29	1,233,841	1,233,841	29,276	41,222	6
7	21	Office Expenses	Patient Days	876,273	29	125,226		29,276	4,184	7
8	24	Education & Seminars	Patient Days	876,273	29	577		29,276	19	8
9	25	Travel	Patient Days	876,273	29	80,576		29,276	2,692	9
10	26	Insurance	Patient Days	876,273	29	(17,938)		29,276	(599)	10
11	27	Employee Benefits	Patient Days	876,273	29	299,243		29,276	9,998	11
12	30	Depreciation	Patient Days	876,273	29	30,566		29,276	1,021	12
13	35	Equipment Rental	Patient Days	876,273	29	17,025		29,276	569	13
14	31	Amortization	Patient Days	876,273	29	3,657		29,276	122	14
15	30	Depreciation	Patient Days	876,273	29	18,405		29,276	615	15
16	32	Interest	Patient Days	876,273	29	30,718		29,276	1,026	16
17	33	Real Estate Taxes	Patient Days	876,273	29	19,475		29,276	651	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,298,679	\$ 1,480,592		\$ 76,798	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1	HUD LOAN		X	MORTGAGE			\$				\$	182,073	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6			X	LINE OF CREDIT								14,901	6	
7													7	
8													8	
9	TOTAL Facility Related						\$					\$	196,974	9
	B. Non-Facility Related*													
10	INTEREST INCOME OFFSET											(3,921)	10	
11													11	
12													12	
13	ALLOCATION FROM PLATINUM											1,026	13	
14	TOTAL Non-Facility Related						\$					\$	(2,895)	14
15	TOTALS (line 9+line14)						\$					\$	194,079	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 15,695 Line # 32

* 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 2010 report.		\$	84,000	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.)		\$	63,256	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(20,744)	3	
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	62,400	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.		\$	41,656	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006		8	
		2007	37,989	9	
		2008	60,687	10	
		2009	61,605	11	
		2010	63,256	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2010 \$		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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COLONIAL HALL CARE CENTER COUNTY BUREAU

FACILITY IDPH LICENSE NUMBER 0049510

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

TELEPHONE (417) 865-8701 FAX #: (417) 865-0682

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. 16-15-303-020	LONG TERM CARE PROPERTY	\$ 62,198.18	\$ 62,198.18
2. 16-15-301-008	LONG TERM CARE PROPERTY	\$ 528.90	\$ 528.90
3. 16-15-301-009	LONG TERM CARE PROPERTY	\$ 528.90	\$ 528.90
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 63,255.98	\$ 63,255.98

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 24,295

B. General Construction Type: Exterior BRICKFrameNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number COLONIAL HALL CARE CENTER

0049510

Report Period Beginning:

1/1/11

Ending:

12/31/11

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			2007		\$ 1,038,400	\$ 37,760	27.5	\$ 37,760	\$	\$ 157,333	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	STORAGE SHED/SLAB (REMOVED \$2,241 PER 2010 CAP COST DES			2007			15				9
10	INSTALL NEW HOT WATER HEATER			2008	5,500		10	550	550	2,200	10
11	INSTALL NEW CARPET-RESIDENT ROOM (REMOVED \$935 PER 20			2008			5				11
12	WEST & SOUTH WALL-PLASTER-VILLA'S CONCRETE			2008	8,000		12	667	667	2,500	12
13	2 BASES/SMOKE DETECTORS			2008	2,510		10	251	251	899	13
14	COACH LIGHTS BY WALK IN (REMOVED \$768 PER 2010 CAP COS			2008			10				14
15	CEILING PLASTER REPAIR (REMOVED \$985 PER 2010 CAP COST I			2008			12				15
16	3 SMOKE DETECTORS (REMOVED \$504 PER 2010 CAP COST DESK			2008			10				16
17	REPLACE TWO HEAT (REMOVED \$1,160 PER 2010 CAP COST DESI			2008			10				17
18	2 LLCO PUSH BUTTON LOCKS (REMOVED \$624 PER 2010 CAP COS			2008			10				18
19	INSTALL NE INTERIOR DOOR (REMOVED \$588 PER 2010 CAP COS			2008			15				19
20	4 OAK DOORS (REMOVED \$2,071 PER 2010 CAP COST DESK AUDIT			2008			15				20
21	1 18" HANDRAIL (REMOVED \$380 PER 2010 CAP COST DESK AUDI			2008			15				21
22	INSTALL POST LIGHT BY MAIN SIDELWALK-ELMORE ELECTRIC			2008			10				22
23	MAT/LABOR REMODEL LAUNRY SHOOT-A.M. REMODELERS-CO			2008	3,500		27.5	127	127	403	23
24	MAT/LABOR INSTALL CONCRETE SIDEWALK & HANDICAP GATE			2008			15				24
25	DOOR GUARD KEY PAD (REMOVED \$266 PER 2010 CAP COST DES			2009			10				25
26	MONITOR - GENERATOR (REMOVED \$1,851 PER 2010 CAP COST I			2009			15				26
27	POST LIGHTS IN PARKING LOT			2009	2,589		15	173	173	460	27
28	PORCH DEMOLITION/REMOVAL (REMOVED \$2,286 PER 2010 CAP			2009			15				28
29	SPRINKLER SYSTEM			2009	11,000		25	440	440	1,063	29
30	FIRE PROTECTION SYSTEM			2010	133,759		25	5,350	5,350	8,471	30
31	LANDSCAPING-CONTRACT-PRINCETON LAWN CARE			2010	4,341		10	434	434	543	31
32	REPLACE ROOF			2010	58,500		27.5	2,127	2,127	2,659	32
33	AWNING SIDE ENTRY (Diposed \$3,700 - 2011)			2010			15	144	144		33
34	CERAMIC TILES 7 ENTRANCES/KITCHEN-CONTRACT-A.M. REMO			2010	65,870		20	3,294	3,294	3,842	34
35	ASPHALT MAIN PARKING AREA			2010	31,240		8	3,905	3,905	4,556	35
36											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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	KITCHEN WALLS-CHANGE ORDER-CONTRACT-A.M. REM	2011	\$ 975	\$	15	\$ 54	\$ 54	\$ 54	37
38	CERAMIC TILES-HALLWAY-CONTRACT-A.M. REMODERS	2011	1,975		20	82	82	82	38
39	FLOORING-HALLWAYS,DINING RMS,NSG STATION,	2011	31,900		20	1,329	1,329	1,329	39
40	RES BATHROOMS -CONTRACT-A.M. REMODELERS								40
41	BIG DINING RM WALLS-CONTRACT-A.M. REMODELERS	2011	1,200		15	67	67	67	41
42	CERAMIC BASEBOARD-CONTRACT-A.M. REMODELERS	2011	9,565		20	359	359	359	42
43	NURSING STATION REMODEL-CONTRACT-A.M. REMODEL	2011	4,385		15	219	219	219	43
44	LANDSCAPING-CONTRACT-TWIN OAKS LANDSCAPING	2011	16,348		10	817	817	817	44
45	CERAMIC BASEBOARD-RES ROOMS-CONTRACT-A.M. REM	2011	3,500		20	88	88	88	45
46	RECEPTION STATION REMODEL-CONTRACT-A.M. REMOI	2011	6,850		15	152	152	152	46
47	HALLWAY & LUNCHROOM WORK-CONTRACT-A.M. REM	2011	5,350		15	89	89	89	47
48				22,321			(22,321)		48
49									49
50									50
51									51
52									52
53									53
54									54
55	38" RED CEDAR DUMPSTER ENCLOSURE	2009	2,673		8	334	334	780	55
56	CONCRETE REPAIR (REMOVED \$1,050 PER 2010 CAP COST	2009			15				56
57	SPRINKLER SYSTEM	2009	3,500		25	140	140	292	57
58	BUILT SOFFITS OVER SPRINKLERS-CONTRACT-A.M. REM	2010	6,500		25	260	260	412	58
59				38			(38)		59
60									60
61									61
62									62
63									63
64									64
65									65
66	ALLOCATION FROM PLATINUM			462		462			66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,459,930	\$ 60,581		\$ 59,674	\$ (907)	\$ 189,669	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	\$261,565	\$20,076	\$23,892	\$3,816		\$105,607	71
72	Current Year Purchases	73,196	1,920	1,920			20,076	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		1,174	1,174				74
75	TOTALS	\$334,761	\$23,170	\$26,986	\$3,816		\$125,683	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$1,794,691	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$83,751	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$86,660	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$2,909	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$315,352	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.

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease

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

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$57,209
- Description: Medical equip \$32,182; printers/copiers \$22,837; postage \$1,656; misc \$534
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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)	\$			

(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.

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	

(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.)

		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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		1,984	130,950	25,900	1,984	156,850	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				124,992		124,992	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab & X-ray	39-02					42,405		42,405	13
14	TOTAL			\$	1,984	\$ 130,950	\$ 193,297	1,984	\$ 324,247	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (14,511)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,605,240		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,974		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)	\$ 1,705,703	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	7,223		15
16	Equipment, at Historical Cost	45,741		16
17	Accumulated Depreciation (book methods)	(51,995)		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)	\$ 969	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,706,672	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 294,185	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	750,000		29
30	Accrued Salaries Payable	52,139		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,400		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	42,720		36
37	Due Others, Adv Billing	(209)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,201,235	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,201,235	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 505,437	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,706,672	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$410,398	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$410,400	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	485,037	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	(390,000)	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)	\$95,037	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)	\$505,437	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			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,207,856	1
2	Discounts and Allowances for all Levels	(237,730)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,970,126	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,501,523	6
7	Oxygen	63,690	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,565,213	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	870	13
14	Non-Patient Meals	9,213	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	165,565	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,136	19
20	Radiology and X-Ray	18,451	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 207,235	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,921	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,921	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION & MISC INCOME	7,741	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,741	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,754,236	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	821,199	31
32	Health Care	2,385,786	32
33	General Administration	1,384,568	33
B. Capital Expense			
34	Ownership	462,069	34
C. Ancillary Expense			
35	Special Cost Centers	167,397	35
36	Provider Participation Fee	48,180	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,269,199	40
41	Income before Income Taxes (line 30 minus line 40)**	485,037	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 485,037	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. TAX RETURN FILED ON CASH BASIS

*** 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.

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	1,959	2,254	\$ 79,507	\$ 35.27	1
2	Assistant Director of Nursing	1,916	2,177	70,518	32.39	2
3	Registered Nurses	16,854	18,140	486,329	26.81	3
4	Licensed Practical Nurses	11,539	12,164	258,829	21.28	4
5	CNAs & Orderlies	56,903	60,006	722,465	12.04	5
6	CNA Trainees					6
7	Licensed Therapist	3,886	4,225	194,917	46.13	7
8	Rehab/Therapy Aides	5,539	6,161	203,027	32.95	8
9	Activity Director	1,896	2,072	29,293	14.14	9
10	Activity Assistants	3,547	3,825	33,895	8.86	10
11	Social Service Workers	3,078	3,321	42,982	12.94	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,071	37,889	18.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,779	19,355	181,951	9.40	15
16	Dishwashers					16
17	Maintenance Workers	1,938	2,174	58,416	26.87	17
18	Housekeepers	10,131	10,386	97,708	9.41	18
19	Laundry	5,619	5,812	54,676	9.41	19
20	Administrator	1,762	2,081	97,098	46.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,822	8,179	106,031	12.96	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)	155,152	164,403	\$ 2,755,531 *	\$ 16.76	34

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	215	\$ 10,316	1-03	35
36	Medical Director	Monthly	4,500	9-03	36
37	Medical Records Consultant	Quarterly	1,840	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,079	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	812	11-03	44
45	Social Service Consultant	8	504	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	239	\$ 24,051		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberCOLONIAL HALL CARE CENTER# 0049510Report Period Beginning: 1/1/11Ending: 12/31/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LOUANNE KENWICK	ADMINISTRATOR		\$ 97,098
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 97,098

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		\$ 246,183
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 246,183

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 160,147	
Unemployment Compensation Insurance	54,184	
FICA Taxes	204,491	
Employee Health Insurance	88,523	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
401K	1,100	
EMPLOYEE BENEFITS - OTHER	39,591	
EMPLOYEE PHYSICAL EXAM		
TOTAL (agree to Schedule V, line 22, col.8)		\$ 548,036

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment	2,098	
Health Care Worker Background Check (Indicate # of checks performed 13)	2,559	
Patient Background Checks	139	
ADVERTISING & MARKETING	46,339	
DUES & SUBSCRIPTIONS	8,253	
LICENSES	1,482	
ALLOCATION FROM PLATINUM	376	
Less: Public Relations Expense	()	
Non-allowable advertising	(46,339)	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,768

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	10,680
ALLOCATION FROM PLATINUM	19
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 10,699

* Attach copy of IMRF notifications

**See instructions.

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?

YES

If YES, give association name and amount.

IL COUNCIL LTC \$8,712
- (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?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

10 YRS
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

7,099

Line

10-2
- (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.

\$

48,180

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?

N/A

Indicate the amount.

\$
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

YES

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

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?

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 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.