

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 CTR</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</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 VLY PKWY</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>(Date) _____</td></tr><tr><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></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(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>												
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	(Telephone) <u>(417) 865-8701</u> Fax # <u>(417) 865-0682</u>																								
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 _____	
☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>PAMELA PHILLIPS</u> Telephone Number: <u>(417) 865-8701</u> Email Address: _____																									

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>88</u>	Skilled (SNF)	<u>88</u>	<u>32,208</u>	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	<u>88</u>	TOTALS	<u>88</u>	<u>32,208</u>	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	<u>15,306</u>		<u>4,251</u>	<u>19,557</u>	8
9	SNF/PED					9
10	ICF		<u>10,379</u>		<u>10,379</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,306</u>	<u>10,379</u>	<u>4,251</u>	<u>29,936</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.95%

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?

YESG. 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 5/1/07

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

YES ☐Date 5/1/07NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 88 and days of care provided 3,820Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

	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	214,736	9,414	8,626	232,776		232,776		232,776			1
2	Food Purchase		175,423		175,423		175,423	(6,999)	168,424			2
3	Housekeeping	84,782	19,093		103,875		103,875		103,875			3
4	Laundry	61,443	20,398		81,841		81,841		81,841			4
5	Heat and Other Utilities			104,586	104,586		104,586	1,452	106,038			5
6	Maintenance	60,474	5	58,445	118,924		118,924	2,187	121,111			6
7	Other (specify):*											7
8	TOTAL General Services	421,435	224,333	171,657	817,425		817,425	(3,360)	814,065			8
	B. Health Care and Programs											
9	Medical Director			8,750	8,750		8,750		8,750			9
10	Nursing and Medical Records	1,643,558	69,952	7,626	1,721,136		1,721,136		1,721,136			10
10a	Therapy	464,255	13,559	50,437	528,251		528,251		528,251			10a
11	Activities	61,826	9,863	7,362	79,051		79,051		79,051			11
12	Social Services	45,497		336	45,833		45,833		45,833			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,215,136	93,374	74,511	2,383,021		2,383,021		2,383,021			16
	C. General Administration											
17	Administrative	98,812		149,355	248,167		248,167	9,247	257,414			17
18	Directors Fees											18
19	Professional Services			263,141	263,141		263,141	(2,209)	260,932			19
20	Dues, Fees, Subscriptions & Promotions			52,720	52,720		52,720	(34,781)	17,939			20
21	Clerical & General Office Expenses	107,593	41,243	42,865	191,701		191,701	39,689	231,390			21
22	Employee Benefits & Payroll Taxes			543,829	543,829		543,829		543,829			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,889	4,889		4,889	258	5,147			24
25	Other Admin. Staff Transportation			32,158	32,158		32,158	1,942	34,100			25
26	Insurance-Prop.Liab.Malpractice			66,764	66,764		66,764	376	67,140			26
27	Other (specify):*							10,279	10,279			27
28	TOTAL General Administration	206,405	41,243	1,155,721	1,403,369		1,403,369	24,801	1,428,170			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,842,976	358,950	1,401,889	4,603,815		4,603,815	21,441	4,625,256			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	93,892	93,930			30
31	Amortization of Pre-Op. & Org.							69	69			31
32	Interest			132,981	132,981		132,981	86,561	219,542			32
33	Real Estate Taxes			62,599	62,599		62,599	573	63,172			33
34	Rent-Facility & Grounds			293,725	293,725		293,725	(293,547)	178			34
35	Rent-Equipment & Vehicles			61,901	61,901		61,901	(4,827)	57,074			35
36	Other (specify):*							4,658	4,658			36
37	TOTAL Ownership			551,244	551,244		551,244	(112,621)	438,623			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			132,816	132,816		132,816		132,816			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			323,443	323,443		323,443		323,443			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			456,259	456,259		456,259		456,259			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,842,976	358,950	2,409,392	5,611,318		5,611,318	(91,180)	5,520,138			45

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

		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	(6,970)	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	(2,705)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(29)	2		13
14	Non-Care Related Interest	(90,845)	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	(148)	21		18
19	Entertainment				19
20	Contributions	(2,275)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(35,136)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,116)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (141,224)		\$	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	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)	50,044		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 50,044		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (91,180)		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

STATE OF ILLINOIS
COLONIAL HALL CARE CTR

Report Period Beginning: ID# 0049510
Ending: 1/1/12
12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	MISCELLANEOUS INCOME	(5,437)	35	2
3	TAXES-GENERAL	(588)	21	3
4	ADJUST S/L DEPR	2,909	30	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	(3,116)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,999)	0	0	0	0	0	0	0	0	0	0	(6,999)	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	1,452	0	0	0	0	0	0	0	0	1,452	5
6	Maintenance	0	0	2,187	0	0	0	0	0	0	0	0	2,187	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,999)	0	3,639	0	0	0	0	0	0	0	0	(3,360)	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	9,247	0	0	0	0	0	0	0	0	9,247	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(6,935)	4,726	0	0	0	0	0	0	0	0	(2,209)	19
20	Fees, Subscriptions & Promotions	(35,136)	0	355	0	0	0	0	0	0	0	0	(34,781)	20
21	Clerical & General Office Expenses	(3,011)	0	42,700	0	0	0	0	0	0	0	0	39,689	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	258	0	0	0	0	0	0	0	0	258	24
25	Other Admin. Staff Transportation	0	0	1,942	0	0	0	0	0	0	0	0	1,942	25
26	Insurance-Prop.Liab.Malpractice	0	0	376	0	0	0	0	0	0	0	0	376	26
27	Other (specify):*	0	0	10,279	0	0	0	0	0	0	0	0	10,279	27
28	TOTAL General Administration	(38,147)	(6,935)	69,883	0	0	0	0	0	0	0	0	24,801	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(45,146)	(6,935)	73,522	0	0	0	0	0	0	0	0	21,441	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	2,909	89,057	1,926	0	0	0	0	0	0	0	0	93,892	30
31	Amortization of Pre-Op. & Org.	0	0	69	0	0	0	0	0	0	0	0	69	31
32	Interest	(93,550)	179,127	984	0	0	0	0	0	0	0	0	86,561	32
33	Real Estate Taxes	0	0	573	0	0	0	0	0	0	0	0	573	33
34	Rent-Facility & Grounds	0	(293,725)	178	0	0	0	0	0	0	0	0	(293,547)	34
35	Rent-Equipment & Vehicles	(5,437)	0	610	0	0	0	0	0	0	0	0	(4,827)	35
36	Other (specify):*	0	4,658	0	0	0	0	0	0	0	0	0	4,658	36
37	TOTAL Ownership	(96,078)	(20,883)	4,340	0	0	0	0	0	0	0	0	(112,621)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(141,224)	(27,818)	77,862	0	0	0	0	0	0	0	0	(91,180)	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
		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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	\$ 293,725	PHCH REALTY, LLC		\$	(293,725)	1
2	V	30	DEPRECIATION				89,057	89,057	2
3	V	32	INTEREST				179,127	179,127	3
4	V	36	AMORTIZATION-LOAN COSTS				4,658	4,658	4
5	V								5
6	V								6
7	V								7
8	V	19	PROFESSIONAL FEES	136,880	PHC CONSULTANTS, LLC		129,945	(6,935)	8
9	V								9
10	V								10
11	V	19	PROFESSIONAL FEES	789	MTS CONSULTING		789		11
12	V								12
13	V								13
14	Total			\$ 431,394			\$ 403,576	\$ * (27,818)	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	\$	PLATINUM HEALTH CARE, LLC	100.00%	\$	\$	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		1,452	1,452	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		2,187	2,187	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		9,247	9,247	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		4,726	4,726	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		355	355	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		39,085	39,085	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		3,615	3,615	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		258	258	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		1,942	1,942	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		376	376	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		10,279	10,279	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		1,329	1,329	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		610	610	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		69	69	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		597	597	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		984	984	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		573	573	32
33	V	34	Office Rent		PLATINUM HEALTH CARE, LLC		178	178	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 77,862	\$ * 77,862	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								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

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	2	3.85	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

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 OrganizationPLATINUM HEALTH CARE, LLC

Street Address7444 LONG AVENUE

City / State / Zip CodeSKOKIE, IL 60077

Phone Number(847) 329-4100

Fax Number(847) 329-7652

	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	5	Utilities	Patient Days	923,219	30	\$44,791	\$	29,936	\$1,452	1
2	6	Repairs & Maintenance	Patient Days	923,219	30	67,446		29,936	2,187	2
3	17	Administrative Salary	Patient Days	923,219	30	285,177	285,177	29,936	9,247	3
4	19	Professional Fees	Patient Days	923,219	30	145,744		29,936	4,726	4
5	20	Fees, Subscriptions	Patient Days	923,219	30	10,954		29,936	355	5
6	21	Clerical Salaries	Patient Days	923,219	30	1,205,375	1,205,375	29,936	39,085	6
7	21	Office Expenses	Patient Days	923,219	30	111,487		29,936	3,615	7
8	24	Education & Seminars	Patient Days	923,219	30	7,956		29,936	258	8
9	25	Travel	Patient Days	923,219	30	59,896		29,936	1,942	9
10	26	Insurance	Patient Days	923,219	30	11,602		29,936	376	10
11	27	Employee Benefits	Patient Days	923,219	30	316,988		29,936	10,279	11
12	30	Depreciation	Patient Days	923,219	30	40,988		29,936	1,329	12
13	35	Equipment Rental	Patient Days	923,219	30	18,824		29,936	610	13
14	31	Amortization	Patient Days	923,219	30	2,134		29,936	69	14
15	30	Depreciation	Patient Days	923,219	30	18,405		29,936	597	15
16	32	Interest	Patient Days	923,219	30	30,356		29,936	984	16
17	33	Real Estate Taxes	Patient Days	923,219	30	17,678		29,936	573	17
18	34	Office Rent	Patient Days	923,219	30	5,488		29,936	178	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$2,401,289	\$1,490,552		\$77,862	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			\$	\$			\$	179,127	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	LAKE FOREST		X	LINE OF CREDIT								42,136	6	
7													7	
8													8	
9	TOTAL Facility Related						\$	\$				\$	221,263	9
	B. Non-Facility Related*													
10	INTEREST INCOME OFFSET											(2,705)	10	
11													11	
12													12	
13	ALLOC FROM PLATINUM HEALTH CARE											984	13	
14	TOTAL Non-Facility Related						\$	\$				\$	(1,721)	14
15	TOTALS (line 9+line14)						\$	\$				\$	219,542	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 15,402 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

[illegible]

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
COLONIAL HALL CARE CTR

COUNTY
BUREAU

FACILITY IDPH LICENSE NUMBER
0049510

CONTACT PERSON REGARDING THIS REPORT
PAMELA PHILLIPS

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

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 16-15-303-020	LONG TERM CARE PROPERTY	\$ 59,955.56	\$ 59,955.56
2. 16-15-301-008	LONG TERM CARE PROPERTY	\$ 509.80	\$ 509.80
3. 16-15-301-009	LONG TERM CARE PROPERTY	\$ 509.80	\$ 509.80
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 60,975.16	\$ 60,975.16

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,295

B. General Construction Type: Exterior BRICK

Frame

Number of Stories 1

C. Does the Operating Entity?

(a) Own the Facility

(X) (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

(X) (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	Facility			\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number COLONIAL HALL CARE CTR

0049510

Report Period Beginning:

1/1/12

Ending:

12/31/12

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2007		\$ 1,038,400	\$ 37,760	27.5	\$ 37,760	\$	\$ 195,093	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	2,750	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	3,167	12
13	2 BASES/SMOKE DETECTORS			2008	2,510		10	251	251	1,151	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			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 DES			2008			10				17
18	2 LLCO PUSH BUTTON LOCKS (REMOVED \$624 PER 2010 CAP CO			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 AUDI			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	530	23
24	MAT/LABOR INSTALL CONCRETE SIDEWALK & HANDICAP GAT			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	633	27
28	PORCH DEMOLITION/REMOVAL (REMOVED \$2,286 PER 2010 CAP			2009			15				28
29	SPRINKLER SYSTEM			2009	11,000		25	440	440	1,503	29
30	FIRE PROTECTION SYSTEM			2010	133,759		25	5,350	5,350	13,822	30
31	LANDSCAPING-CONTRACT-PRINCETON LAWN CARE			2010	4,341		10	434	434	977	31
32	REPLACE ROOF			2010	58,500		27.5	2,127	2,127	4,786	32
33	AWNING SIDE ENTRY (Diposed \$3,700 - 2011)			2010			15				33
34	CERAMIC TILES 7 ENTRANCES/KITCHEN-CONTRACT-A.M. REM			2010	65,870		20	3,294	3,294	7,136	34
35	ASPHALT MAIN PARKING AREA			2010	31,240		8	3,905	3,905	8,461	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	10
	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. REMODELERS	2011	\$ 975	\$	15	\$ 65	\$ 65	\$ 119	37
38	CERAMIC TILES-HALLWAY-CONTRACT-A.M. REMODELERS	2011	1,975		20	99	99	181	38
39	FLOORING-HALLWAYS,DINING RMS,NSG STATION,	2011	31,900		20	1,595	1,595	2,924	39
40	RES BATHROOMS -CONTRACT-A.M. REMODELERS								40
41	BIG DINING RM WALLS-CONTRACT-A.M. REMODELERS	2011	1,200		15	80	80	147	41
42	CERAMIC BASEBOARD-CONTRACT-A.M. REMODELERS	2011	9,565		20	478	478	837	42
43	NURSING STATION REMODEL-CONTRACT-A.M. REMODELERS	2011	4,385		15	292	292	512	43
44	LANDSCAPING-CONTRACT-TWIN OAKS LANDSCAPING	2011	16,348		10	1,635	1,635	2,452	44
45	CERAMIC BASEBOARD-RES ROOMS-CONTRACT-A.M. REMODELERS	2011	3,500		20	175	175	263	45
46	RECEPTION STATION REMODEL-CONTRACT-A.M. REMODELERS	2011	6,850		15	457	457	609	46
47	HALLWAY & LUNCHROOM WORK-CONTRACT-A.M. REMODELERS	2011	5,350		15	357	357	446	47
48	REMODEL WALL-RES ROOM-CONTRACT-A.M. REMODELERS	2012	2,500		15	111	111	111	48
49	REMODEL SHOWER RM 2-CONTRACT-A.M. REMODELERS	2012	6,438		15	322	322	322	49
50	5 TON CONDENSING UNIT	2012	4,762		15	317	317	317	50
51				24,904			(24,904)		51
52									52
53									53
54									54
55	38" RED CEDAR DUMPSTER ENCLOSURE	2009	2,673		8	334	334	1,114	55
56	CONCRETE REPAIR (REMOVED \$1,050 PER 2010 CAP COST)	2009			15				56
57	SPRINKLER SYSTEM	2009	3,500		25	140	140	432	57
58	BUILT SOFFITS OVER SPRINKLERS-CONTRACT-A.M. REMODELERS	2010	6,500		25	260	260	672	58
59				38			(38)		59
60									60
61									61
62									62
63									63
64									64
65									65
66	ALLOCATION FROM PLATINUM			427		427			66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,473,630	\$ 63,129		\$ 62,222	\$ (907)	\$ 251,467	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	\$7,633	\$26,114	\$29,930	\$3,816		\$137,457	71
72	Current Year Purchases	334,762	280	280			280	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum Health Care		1,499	1,499				74
75	TOTALS	\$342,395	\$27,893	\$31,709	\$3,816		\$137,737	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 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)	\$1,816,025	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$91,022	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$93,931	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)	\$389,204	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

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

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$61,901
- Description: Med Eqp \$14,983; Prtr/cprs \$36,383; Therapy \$884; Postage \$1,251; Dish mach \$861; Other \$7,539
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.)

		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	\$		\$	\$		\$
2	Licensed Speech and Language Development Therapist	10a-03	hrs		289	20,262		289	20,262	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		443	30,175		443	30,175	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				111,414		111,414	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					21,402		21,402	13
14	TOTAL			\$	732	\$ 50,437	\$ 132,816	732	\$ 183,253	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	\$ 123,668	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,385,047		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,649		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)	\$ 1,600,364	\$	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)	(52,964)		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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,600,364	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 334,746	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	145,000		29
30	Accrued Salaries Payable	76,013		30
31	Accrued Taxes Payable (excluding real estate taxes)			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	Accrued Expenses	78,945		36
37	Due Others	(93,176)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 541,528	\$	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)	\$ 541,528	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,058,836	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,600,364	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 505,437	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 505,438	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	793,398	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	(240,000)	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)	\$ 553,398	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)	\$ 1,058,836	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		2
I. Revenue	Amount		
A. Inpatient Care			
1Gross Revenue -- All Levels of Care	\$ 4,616,548	1	
2Discounts and Allowances for all Levels	(48,308)	2	
3SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,568,240	3	
B. Ancillary Revenue			
4Day Care		4	
5Other Care for Outpatients		5	
6Therapy	1,550,474	6	
7Oxygen	92,360	7	
8SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,642,834	8	
C. Other Operating Revenue			
9Payments for Education		9	
10Other Government Grants		10	
11CNA Training Reimbursements		11	
12Gift and Coffee Shop		12	
13Barber and Beauty Care	292	13	
14Non-Patient Meals	6,970	14	
15Telephone, Television and Radio		15	
16Rental of Facility Space		16	
17Sale of Drugs	165,696	17	
18Sale of Supplies to Non-Patients		18	
19Laboratory	8,360	19	
20Radiology and X-Ray	4,182	20	
21Other Medical Services		21	
22Laundry		22	
23SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 185,500	23	
D. Non-Operating Revenue			
24Contributions		24	
25Interest and Other Investment Income***	2,705	25	
26SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,705	26	
E. Other Revenue (specify):****			
27Settlement Income (Insurance, Legal, Etc.)		27	
28MISC INCOME	5,437	28	
28a		28a	
29SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,437	29	
30TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,404,716	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31General Services	817,425	31	
32Health Care	2,383,021	32	
33General Administration	1,403,369	33	
B. Capital Expense			
34Ownership	551,244	34	
C. Ancillary Expense			
35Special Cost Centers	132,816	35	
36Provider Participation Fee	323,443	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,611,318	40	
41Income before Income Taxes (line 30 minus line 40)**	793,398	41	
42Income Taxes		42	
43NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 793,398	43	

III. Net Inpatient Revenue detailed by Payer Source			
44Medicaid - Net Inpatient Revenue	\$ 2,249,263	44	
45Private Pay - Net Inpatient Revenue	1,718,407	45	
46Medicare - Net Inpatient Revenue	561,764	46	
47Other-(specify)	25,405	47	
48Other-(specify) Pt B/Bad Debt Exp/Prior Year Adj	13,401	48	
49TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,568,240	49	

* 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	2,007	2,290	\$ 81,627	\$ 35.64	1
2	Assistant Director of Nursing	1,996	2,218	66,985	30.20	2
3	Registered Nurses	16,082	17,401	472,482	27.15	3
4	Licensed Practical Nurses	12,455	13,180	279,326	21.19	4
5	CNAs & Orderlies	57,603	61,545	743,138	12.07	5
6	CNA Trainees					6
7	Licensed Therapist	3,155	3,549	175,675	49.50	7
8	Rehab/Therapy Aides	7,630	8,609	288,580	33.52	8
9	Activity Director	1,822	1,992	28,353	14.23	9
10	Activity Assistants	3,438	3,688	33,473	9.08	10
11	Social Service Workers	3,222	3,469	45,497	13.12	11
12	Dietician					12
13	Food Service Supervisor	1,929	2,082	38,040	18.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,183	18,915	176,696	9.34	15
16	Dishwashers					16
17	Maintenance Workers	2,000	2,169	60,474	27.88	17
18	Housekeepers	8,748	9,150	84,782	9.27	18
19	Laundry	6,737	6,970	61,443	8.82	19
20	Administrator	1,862	2,122	98,812	46.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,832	8,287	107,593	12.98	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)	156,701	167,636	\$ 2,842,976 *	\$ 16.96	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	180	\$ 8,626	1.3	35
36	Medical Director	Monthly	8,750	9.3	36
37	Medical Records Consultant	Quarterly	1,840	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant		5,786	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	612	11.3	44
45	Social Service Consultant	5	336	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	197	\$ 25,950		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

0049510

Report Period Beginning:

1/1/12

Page 21

Ending: 12/31/12

Facility Name & ID Number

COLONIAL HALL CARE CTR

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
LOUANNE KENWICK	ADMINISTRATOR		\$ 98,812	Workers' Compensation Insurance		\$ 177,101	IDPH License Fee	\$
				Unemployment Compensation Insurance		52,472	Advertising: Employee Recruitment	833
				FICA Taxes		205,552	Health Care Worker Background Check	1,053
				Employee Health Insurance		95,118	(Indicate # of checks performed 16)	
				Employee Meals			Patient Background Checks	107
				Illinois Municipal Retirement Fund (IMRF)*			ADVERTISING & MARKETING	35,136
				401K		1,300	DUES & SUBSCRIPTIONS	10,253
				EMPLOYEE BENEFITS - OTHER		12,286	LICENSES	5,445
				EMPLOYEE PHYSICAL EXAM				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							ALLOCATION FROM PLATINUM	355
							Less: Public Relations Expense	()
							Non-allowable advertising	(35,136)
							Yellow page advertising	()
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 543,829	TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
SEE ATTACHED SCHEDULE			\$ 263,141				Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	4,889
							ALLOCATION FROM PLATINUM	258
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL			TOTAL	\$ 5,147

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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

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

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 \$8,510
- (3)

Did the nursing home make political contributions or payments to a political action organization?

YES

If YES, have these costs been properly adjusted out of the cost report?

YES
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?
- (6)

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

\$

7,195

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.

\$

323,443

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.

\$

N/A

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$

N/A
- (16)

Travel and Transportation

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

NO

If YES, attach a complete explanation.

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

NO

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

\$

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?

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.