

Facility Name & ID Number Colonial Hall Rehab & Nursing Center

0046953 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 N/A

	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 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF	14,532	8,238	4,670	27,440	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,532	8,238	4,670	27,440	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.43%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7.

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 04/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/2005 NO

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 4,352

Medicare Intermediary AdminaStar Federal Springfield

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

STATE OF ILLINOIS

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Facility Name & ID Number Colonial Hall Rehab & Nursing Center # 0046953 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	174,240	11,991	7,654	193,885		193,885		193,885		1
2	Food Purchase		112,344		112,344		112,344	(9,954)	102,390		2
3	Housekeeping	65,567	17,671	4,934	88,172		88,172		88,172		3
4	Laundry	46,978	20,998		67,976		67,976		67,976		4
5	Heat and Other Utilities			82,564	82,564		82,564		82,564		5
6	Maintenance	87,035		31,968	119,003		119,003		119,003		6
7	Other (specify):*										7
8	TOTAL General Services	373,820	163,004	127,120	663,944		663,944	(9,954)	653,990		8
B. Health Care and Programs											
9	Medical Director			6,500	6,500		6,500		6,500		9
10	Nursing and Medical Records	1,541,811	64,499	3,920	1,610,230		1,610,230		1,610,230		10
10a	Therapy		3,601	269,670	273,271		273,271		273,271		10a
11	Activities	52,881	6,900	784	60,565		60,565		60,565		11
12	Social Services	34,359	46	1,694	36,099		36,099		36,099		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,629,051	75,046	282,568	1,986,665		1,986,665		1,986,665		16
C. General Administration											
17	Administrative	79,215			79,215		79,215		79,215		17
18	Directors Fees										18
19	Professional Services			72,593	72,593		72,593		72,593		19
20	Dues, Fees, Subscriptions & Promotion			10,740	10,740		10,740		10,740		20
21	Clerical & General Office Expense	123,947	18,839	21,113	163,899		163,899	(6,485)	157,414		21
22	Employee Benefits & Payroll Tax			335,015	335,015		335,015		335,015		22
23	Inservice Training & Education			192	192		192		192		23
24	Travel and Seminars			1,175	1,175		1,175		1,175		24
25	Other Admin. Staff Transportation			7,870	7,870		7,870		7,870		25
26	Insurance-Prop.Liab.Malpractice			75,635	75,635		75,635		75,635		26
27	Other (specify):*										27
28	TOTAL General Administration	203,162	18,839	524,333	746,334		746,334	(6,485)	739,849		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,206,033	256,889	934,021	3,396,943		3,396,943	(16,439)	3,380,504		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.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number

Colonial Hall Rehab & Nursing Center

#0046953

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			5,442	5,442		5,442	(618)	4,824			30
31	Amortization of Pre-Op. & Org			139	139		139		139			31
32	Interest			41,582	41,582		41,582		41,582			32
33	Real Estate Taxes			35,109	35,109		35,109		35,109			33
34	Rent-Facility & Grounds			270,449	270,449		270,449		270,449			34
35	Rent-Equipment & Vehicle:			29	29		29		29			35
36	Other (specify): ³											36
37	TOTAL Ownership			352,750	352,750		352,750	(618)	352,132			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:		141,306	2,340	143,646		143,646		143,646			39
40	Barber and Beauty Shops			18,151	18,151		18,151		18,151			40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify): ³ Nonallowable Cost			79,255	79,255		79,255	(79,255)				43
44	TOTAL Special Cost Centers		141,306	147,926	289,232		289,232	(79,255)	209,977			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,206,033	398,195	1,434,697	4,038,925		4,038,925	(96,312)	3,942,613			45

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

**See schedule of adjustments attached at end of cost report.

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(7,804)	2		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund	(618)	30		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,526)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(75)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(31,200)	43		24
25	Fund Raising, Advertising and Promotions	(34,318)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch5A	(20,771)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (96,312)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (96,312)		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		x	\$		38
39						39
40	Gift and Coffee Shop		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Colonial Hall Rehab & Nursing Center

Provider #: 0046953

01/01/2006 to 12/31/2006

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
To offset Vending Income	(2,150)	2
To offset Other Income	(6,459)	21
To offset Jury Duty Income	(26)	21
To disallow Collection Exp	(80)	43
To disallow Laboratory Exp	(6,955)	43
To disallow Radiology Exp	(5,101)	43
Total	<u>(20,771)</u>	

Colonial Hall Rehab & Nursing Center

ID# 0046953

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Colonial Hall Rehab & Nursing Center

0046953

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,804)	0	0	0	0	0	0	0	0	0	0	(7,804)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,804)	0	0	0	0	0	0	0	0	0	0	(7,804)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,804)	0	0	0	0	0	0	0	0	0	0	(7,804)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Colonial Hall Rehab & Nursing Center # 0046953 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(618)	0	0	0	0	0	0	0	0	0	0	(618) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(618)	0	0	0	0	0	0	0	0	0	0	(618) 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):*	(67,119)	0	0	0	0	0	0	0	0	0	0	(67,119) 43
44	TOTAL Special Cost Centers	(67,119)	0	0	0	0	0	0	0	0	0	0	(67,119) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(75,541)	0	0	0	0	0	0	0	0	0	0	(75,541) 45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Nathan Langsner	99%	River Shore Rehabilitation and Nursing Center	Marseilles, IL	N/A		
David Langsner	1%					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Colonial Hall Rehab & Nursing Center # 0046953 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	Nathan Langsner	Owner	Administrative	99.0000%	0				\$ 0	1
2	David Langsner	Owner	Administrative	1.0000%	0				0	2
3	Ruth Langsner	Relative	Bookkeeper		49,277	20	50%	Salary	51,547	21-1
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 51,547	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 Rehab & Nursing Center SCH7A
0046953
Report Period Beginning: 01/01/2006 **Ending:** 12/31/2006

Individual Name	Facility Name	Hours	Amount
Nathan Langsner	River Shore Rehabilitstion & Nursing Center	0	0
David Langsner	River Shore Rehabilitstion & Nursing Center	0	0
Ruth Langsner	River Shore Rehabilitstion & Nursing Center	20	49,277

Facility Name & ID Number Colonial Hall Rehab & Nursing Center # 0046953 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

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

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

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

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
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank		X	Line of Credit				713,866			41,582	6
7												7
8												8
9	TOTAL Facility Related						\$	\$ 713,866			\$ 41,582	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$ 713,866			\$ 41,582	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Colonial Hall Rehab & Nursing Center COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0046953

CONTACT PERSON REGARDING THIS REPORT David Langsner

TELEPHONE (847) 905-3206 FAX #: (847) 905-3030

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 16-15-301-008	Long Term Care Property	\$ 446.70	\$ 446.70
2. 16-15-301-009	Long Term Care Property	\$ 446.70	\$ 446.70
3. 16-15-303-020	Long Term Care Property	\$ 33,468.64	\$ 33,468.64
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 34,362.04	\$ 34,362.04

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 NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Colonial Hall Rehab & Nursing Center

0046953 Report Period Beginning:

01/01/2006 Ending: 12/31/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,295 B. General Construction Type: Exterior Brick Frame Steel Stud Number 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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

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: 7,105 2. Number of Years Over Which it is Being Amortized 5
3. Current Period Amortization: 139 4. Dates Incurred: 4/01/05

Nature of Costs: Loan Cost (\$7,105)

(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	<u>N/A</u>			\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Colonial Hall Rehab & Nursing Center

0046953

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Parking Lot		2005	10,776	1,024	8	1,347	323	2,020	9
10	Water Heater		2005	4,495	115	10	450	335	675	10
11	Water Heater		2005	4,174	107	10	417	310	626	11
12	Windows		2005	25,536	655	39	655		982	12
13	Carpet		2005	2,767	763	10	277	(486)	415	13
14	Carpet for Lobby		2006	2,664	31	10	122	91	122	14
15	Air Condition Upgrade		2006	7,975	94	39	94		94	15
16	Rebuild Attic Wall doe Smoke Dividers		2006	18,391	216	39	216		216	16
17	Smoke Detectors		2006	3,878	46	39	46		46	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 80,656	\$ 3,051		\$ 3,624	\$ 573	\$ 5,196	70

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

Facility Name & ID Number: Colonial Hall Rehab & Nursing Cente # 0046953 Report Period Beginning: 01/01/2006 Ending: 12/31/2006
 XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$ 874	\$ 240	\$ 125	\$ (115)	5 Yrs	\$ 212	71
72	Current Year Purchases	7,031	1,051	525	(526)	5-7 Yrs	525	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 7,905	\$ 1,291	\$ 650	\$ (641)		\$ 737	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76			2006	\$ 5,500	\$ 1,100	\$ 550	\$ (550)	5 Yrs	\$ 550	76
77										77
78										78
79										79
80	TOTALS			\$ 5,500	\$ 1,100	\$ 550	\$ (550)		\$ 550	80

E. Summary of Care-Related Asset

	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)	\$ 94,061	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,442	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 4,824	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (618)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,483	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-Progres

	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 1

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Colonial Priceton Property LLC
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO
 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:				\$ 269,273			3
4	Additions							4
5								5
6	Storage Unit Rental				1,176			6
7	TOTAL				\$ 270,449			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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

9. Option to Buy: YES NO Terms: N/A *

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: \$ 29 Description: \$29 Postage Meter

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10a,C2	hrs	\$		\$ 122,086	\$		\$ 122,086	1
2	Licensed Speech and Language Development Therapist	L10a,C3	hrs			4,170			4,170	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a,C3	hrs			143,414			143,414	4
5	Physician Care		visits							5
6	Dental Care		visits			102			102	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescripts				107,922		107,922	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Sch16A					2,340	36,985		39,325	13
14	TOTAL			\$		\$ 272,112	\$ 144,907		\$ 417,019	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Colonial Hall Rehab & Nursing Center

Provider #: 0046953

01/01/2006 to 12/31/2006

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

Service	Line Reference	Outside Practioner		Supplies
		Units	Cost	
Therapy And Rehab. Supplies	L 10A C 2			3,601
Ventilation Equipment	L 10A C 3		2,340	
Air Fluidized Beds	L 39 C 2			0
Oxygen	L 39 C 2			5,256
Other Services Medicare	L 39 C 2			177
Food Pump	L 39 C 2			-74
Medical Supplies Chargeable				28,025
Total			2,340	36,985

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 284,161	\$ 284,161	1
2	Cash-Patient Deposits	3,835	3,835	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 57,166)	644,008	644,008	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,726	33,726	6
7	Other Prepaid Expenses	16,551	16,551	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due From Others</u>	75,486	75,486	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,057,767	\$ 1,057,767	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	80,656	80,656	15
16	Equipment, at Historical Cost	13,405	13,405	16
17	Accumulated Depreciation (book methods)	(6,294)	(6,483)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,090	7,090	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,244)	(5,244)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Utility Deposit</u>	1,127	1,127	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 90,740	\$ 90,551	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,148,507	\$ 1,148,318	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 119,993	\$ 119,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,818	6,818	28
29	Short-Term Notes Payable	713,866	713,866	29
30	Accrued Salaries Payable	144,655	144,655	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,525	7,525	31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,080	36,080	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Sch 17A</u>	87,466	87,466	36
37	<u>See Sch 17A</u>	292,414	292,414	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,408,817	\$ 1,408,817	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)	\$ 1,408,817	\$ 1,408,817	46
47	TOTAL EQUITY(page 18, line 24)	\$ (260,310)	\$ (260,499)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,148,507	\$ 1,148,318	48

*(See instructions.)

Colonial Hall Rehab & Nursing Center
0046953
12/31/2006

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

A. Current Assets

<u>Other Current Assets (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Due From Others	75,486	75,486
Total Line 9 - Other Current Assets(specify):	<u>75,486</u>	<u>75,486</u>

B. Long Term Assets

<u>Other Long Term Assets (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Total Line 23 - Other Long Term Assets Assets(spec	<u>0</u>	<u>0</u>

C. Current Liabilities

<u>Other Current Liabilities (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Expenses	101,715	101,715
A/R - Due To Medicaid	(19,362)	(19,362)
Payroll Deduction - Life Insurance	1,496	1,496
Payroll Deduction - 401K	3,617	3,617
Medicare Settlements		
Medicare Settlements Prior		
Accrued Assessment Tax		
Total Line 36 - Other Current Liabilities(specify):	<u>87,466</u>	<u>87,466</u>

Other Current Liabilities (specify):

<u>Other Current Liabilities (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Due To Others	1,000	1,000
Due To Others Related Parties		
Due To Prior Owners	491,414	491,414
Total Line 37 - Other Current Liabilities(specify):	<u>492,414</u>	<u>492,414</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (140,616)	1
2	Restatements (describe):		2
3	To record bad debts from last year review	(21,517)	3
4	To record Member Equity from last year review	1,000	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (161,133)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(99,177)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (99,177)	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)	\$ (260,310)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

Facility Name & ID Number Colonial Hall Rehab & Nursing Center

0046953

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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 expenses.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,648,499	1
2	Discounts and Allowances for all Level	(934,456)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,714,043	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	900,925	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 900,925	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,911	13
14	Non-Patient Meals	7,804	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	102,230	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	33,719	19
20	Radiology and X-Ray	3,286	20
21	Other Medical Services	144,095	21
22	Laundry	5,100	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 316,145	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch19A</u>	8,635	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,635	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,939,748	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	663,944	31
32	Health Care	1,986,665	32
33	General Administrator	746,334	33
B. Capital Expense			
34	Ownership	352,750	34
C. Ancillary Expense			
35	Special Cost Centers	241,052	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)*	\$ 4,038,925	40
41	Income before Income Taxes (line 30 minus line 40)**	(99,177)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (99,177)	43

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

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

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

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

Colonial Hall Rehab & Nursing Center
0046953
12/31/2006

Schedule 19A

XVII. INCOME STATEMENT

Revenue

<u>E. Other Revenue (specify):</u>	<u>Amount</u>
Vending Income	2,150
Other Income	6,459
Jury Duty	26
	<hr/>
Total Line 28 - Other Revenue (specify):	<u><u>8,635</u></u>

Facility Name & ID Number Colonial Hall Rehab & Nursing Center

0046953

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

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	1,784	2,115	\$ 69,034	\$ 32.64	1
2	Assistant Director of Nursing	1,754	2,133	61,432	28.80	2
3	Registered Nurses	12,863	15,609	367,230	23.53	3
4	Licensed Practical Nurses	11,498	12,216	242,877	19.88	4
5	CNAs & Orderlies	50,642	54,863	625,753	11.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,763	2,032	28,723	14.14	9
10	Activity Assistants	2,810	3,057	24,158	7.90	10
11	Social Service Worker	2,171	2,316	34,359	14.84	11
12	Dietician					12
13	Food Service Supervisor	1,909	2,162	45,049	20.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,532	6,116	63,709	10.42	15
16	Dishwashers	8,177	8,869	65,482	7.38	16
17	Maintenance Worker	5,378	6,176	87,035	14.09	17
18	Housekeepers	7,788	8,447	65,567	7.76	18
19	Laundry	5,679	5,970	46,978	7.87	19
20	Administrator	1,860	2,129	79,215	37.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,992	6,555	123,947	18.91	24
25	Vocational Instructor					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,654	1,915	28,814	15.05	31
32	Other Health C: See Schedule 20A	8,016	9,331	146,671	15.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,270	152,011	\$ 2,206,033 *	\$ 14.51	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	149	\$ 7,654	L. 1, C. 3	35
36	Medical Director	monthly	6,500	L. 9, C. 3	36
37	Medical Records Consultant	monthly	455	L. 10, C. 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,363	L. 10, C. 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	16	784	L. 11, C. 3	44
45	Social Service Consultant	26	1,694	L. 12, C. 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	191	\$ 20,450		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Colonial Hall Rehab & Nursing Center
 0046953
 12/31/2006

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

LINE 32 - Other (Health Care specify)

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
Supply Clerk	1,844	2,074	\$ 25,104	12.10
Ward Clerk	1,835	2,122	\$ 25,638	12.08
Rehab Aides	2,533	2,986	\$ 36,473	12.21
Care Plan Coordinator	1,804	2,149	\$ 59,456	27.67
Total Line 32 - Other	8,016	9,331	\$ 146,671	\$ 15.72

XVIII. STAFFING AND SALARY COSTS

LINE 33 - Other (specify)

	<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
Total Line 33 - Other	0	0	\$ -	#DIV/0!

Colonial Hall Rehab & Nursing Center
0046953
12/31/2006

Schedule 20B

XVIII. Consultant Services
LINE 46

<u># of Hrs.</u>	<u>Reporting Period</u>	<u>Schedule V</u>
<u>Actually</u>	<u>Total Consultant</u>	<u>Line &</u>
<u>Worked</u>	<u>Costs</u>	<u>Column</u>

Total Line 46 - Other

0 \$ -

Colonial Hall Rehab & Nursing Center

Provider #: 0046953

01/01/2006 to 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Care Centers, Inc	Bookkeeping Services	35,123
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Total (agree to Schedule V, line 19, column 3)	72,593
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Total (agree to Schedule V, line 19, column 8)	<u>72,593</u>
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Facility Name & ID Number Colonial Hall Rehab & Nursing Center

0046953

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 6.69 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 29,373 Line 10
- (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 N/A
- (9) Are you presently operating under a sublease agreement? YES _____ NO X
- (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: N/A
- (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 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 if the patient census listed on page 2, Section B No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions _____
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount \$ 7,804
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation _____
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such program during this reporting period. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees _____

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	174,240	11,991	7,654	193,885	0	193,885	0	193,885
2. Food Purchase	0	112,344	0	112,344	0	112,344	-9,954	102,390
3. Housekeeping	65,567	17,671	4,934	88,172	0	88,172	0	88,172
4. Laundry	46,978	20,998	0	67,976	0	67,976	0	67,976
5. Heat and Other Utilities	0	0	82,564	82,564	0	82,564	0	82,564
6. Maintenance	87,035	0	31,968	119,003	0	119,003	0	119,003
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	373,820	163,004	127,120	663,944	0	663,944	-9,954	653,990
9. Medical Director	0	0	6,500	6,500	0	6,500	0	6,500
10. Nursing & Medical Records	1,541,811	64,499	3,920	1,610,230	0	1,610,230	0	1,610,230
10a. Therapy	0	3,601	269,670	273,271	0	273,271	0	273,271
11. Activities	52,881	6,900	784	60,565	0	60,565	0	60,565
12. Social Services	34,359	46	1,694	36,099	0	36,099	0	36,099
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,629,051	75,046	282,568	1,986,665	0	1,986,665	0	1,986,665
17. Administrative	79,215	0	0	79,215	0	79,215	0	79,215
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	72,593	72,593	0	72,593	0	72,593
20. Fees, Subscriptions & Promotion	0	0	10,740	10,740	0	10,740	0	10,740
21. Clerical & General Office	123,947	18,839	21,113	163,899	0	163,899	-6,485	157,414
22. Employee Benefits & Payroll	0	0	335,015	335,015	0	335,015	0	335,015
23. Inservice Training & Education	0	0	192	192	0	192	0	192
24. Travel and Seminar	0	0	1,175	1,175	0	1,175	0	1,175
25. Other Admin. Staff Trans	0	0	7,870	7,870	0	7,870	0	7,870
26. Insurance-Prop.Liab.Malpractice	0	0	75,635	75,635	0	75,635	0	75,635
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	203,162	18,839	524,333	746,334	0	746,334	-6,485	739,849
29. Total General Administrative	2,206,033	256,889	934,021	3,396,943	0	3,396,943	-16,439	3,380,504
30. Depreciation	0	0	5,442	5,442	0	5,442	-618	4,824
31. Amortization of Pre-Op. & Org.	0	0	139	139	0	139	0	139
32. Interest	0	0	41,582	41,582	0	41,582	0	41,582
33. Real Estate	0	0	35,109	35,109	0	35,109	0	35,109
34. Rent - Facility & Grounds	0	0	270,449	270,449	0	270,449	0	270,449
35. Rent - Equipment & Vehicles	0	0	29	29	0	29	0	29
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	352,750	352,750	0	352,750	-618	352,132
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	141,306	2,340	143,646	0	143,646	0	143,646
40. Barber and Beauty Shop	0	0	18,151	18,151	0	18,151	0	18,151
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	48,180	48,180	0	48,180	0	48,180
43. Other (specify):*	0	0	79,255	79,255	0	79,255	-79,255	0
44. Total Special Cost Ce	0	141,306	147,926	289,232	0	289,232	-79,255	209,977
45. Grand Total	2,206,033	398,195	1,434,697	4,038,925	0	4,038,925	-96,312	3,942,613

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	284,161	284,161
2. Cash - Patient Deposits	3,835	3,835
3. Accounts & Notes Recievable	644,008	644,008
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	33,726	33,726
7. Other Prepaid Expenses	16,551	16,551
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	75,486	75,486
10. Total current assets	1,057,767	1,057,767
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	0
14. Buildings, at Historical Cost	0	0
15. Leasehold Improvements, Historical Cost	80,656	80,656
16. Equipment, at Historical Cost	13,405	13,405
17. Accumulated Depreciation (book methods)	-6,294	-6,483
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	7,090	7,090
20. Accum Amort - Org/Pre-Op Costs	-5,244	-5,244
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	1,127	1,127
24. Total Long-Term Assets	90,740	90,551
25. Total Assets	1,148,507	1,148,318
CURRENT LIABILITIES		
26. Accounts Payable	119,993	119,993
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	6,818	6,818
29. Short-Term Notes Payable	713,866	713,866
30. Accrued Salaries Payable	144,655	144,655
31. Accrued Taxes Payable	7,525	7,525
32. Accrued Real Estate Taxes	36,080	36,080
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	87,466	87,466
37. Other Current Liabilities (specify):	292,414	292,414
38. Total Current Liabilities	1,408,817	1,408,817
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	0
46. Total Liabilities	1,408,817	1,408,817
47. Total Equity	-260,310	-260,499
48. Total Liabilities and Equity	1,148,507	1,148,318

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,648,499
2. Discounts and Allowances for all Levels	-934,456
Subtotal - Inpatient Care	2,714,043
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	900,925
7. Oxygen	0
Subtotal - Ancillary Revenue	900,925
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	19,911
14. Non-Patient Meals	7,804
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	102,230
18. Sale of Supplies to Non-Patients	0
19. Laboratory	33,719
20. Radiology and X-Ray	3,286
21. Other Medical Services	144,095
22. Laundry	5,100
Subtotal - Other Operating Revenue	316,145
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	8,635
28. Other Revenue (specify):	0
Subtotal - Other Revenue	8,635
30. Total Revenue	3,939,748
31. General Services	484,027
32. Health Care	1,407,005
33. General Administration	566,948
34. Ownership	242,110
35. Special Cost Centers	160,511
35. Provider Participation Fee	36,300
37. Other	0
40. Total Expenses	2,896,901
41. Income Before Income Taxes	1,042,847
42. Income Taxes	0
43. Net Income or Loss for the Year	1,042,847