

		FOR BHF USE					

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**2008**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2008)**

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

<p><b>I. IDPH License ID Number:</b> <u>0049510</u></p> <p><b>Facility Name:</b> <u>COLONIAL HALL CARE CENTER</u></p> <p><b>Address:</b> <u>515 BUREAU VALLEY PARKWAY</u> <u>PRINCETON</u> <u>61356</u>          Number City Zip Code</p> <p><b>County:</b> <u>BUREAU</u></p> <p><b>Telephone Number:</b> <u>( 815 ) 875-3347</u> Fax # <u>( 815 ) 875-2012</u></p> <p><b>HFS ID Number:</b> <u>200837520001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>5/1/07</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>DARRYL BUEKER</u> <b>Telephone Number:</b> <u>( 417 ) 865-8701</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/08</u> to <u>12/31/08</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) _____</td> <td></td> </tr> <tr> <td></td> <td>(Title) _____</td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>DARRYL BUEKER, CPA</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>BKD, LLP</u> <u>P. O. BOX 1190, SPRINGFIELD, MO 65801-1190</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>( 417 ) 865-8701</u> Fax # <u>(417) 865-0682</u></td> <td></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>DARRYL BUEKER, CPA</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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Facility Name & ID Number COLONIAL HALL CARE CENTER

# 0049510 Report Period Beginning: 1/01/08 Ending: 12/31/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,208	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	32,208	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	16,124	8,534	4,462	29,120	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,124	8,534	4,462	29,120	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.41%

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

NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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 5/1/07 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 3,814

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	171,970	8,732	6,387	187,089		187,089		187,089		1
2	Food Purchase		135,651		135,651		135,651	(5,800)	129,851		2
3	Housekeeping	94,164	20,929		115,093		115,093		115,093		3
4	Laundry	55,119	20,407		75,526		75,526		75,526		4
5	Heat and Other Utilities			88,024	88,024		88,024	3,060	91,084		5
6	Maintenance	54,757		37,886	92,643		92,643	3,573	96,216		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>376,010</b>	<b>185,719</b>	<b>132,297</b>	<b>694,026</b>		<b>694,026</b>	<b>833</b>	<b>694,859</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,058	6,058		6,058		6,058		9
10	Nursing and Medical Records	1,399,051	152,951	5,363	1,557,365		1,557,365		1,557,365		10
10a	Therapy	160,090		58,795	218,885		218,885		218,885		10a
11	Activities	49,602	7,806	5,631	63,039		63,039		63,039		11
12	Social Services	36,422		4,727	41,149		41,149		41,149		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,645,165</b>	<b>160,757</b>	<b>80,574</b>	<b>1,886,496</b>		<b>1,886,496</b>		<b>1,886,496</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	87,068		96,000	183,068		183,068	(79,071)	103,997		17
18	Directors Fees										18
19	Professional Services			93,263	93,263		93,263	3,990	97,253		19
20	Dues, Fees, Subscriptions & Promotions			98,941	98,941		98,941	(87,145)	11,796		20
21	Clerical & General Office Expenses	76,841	35,962	54,347	167,150		167,150	38,647	205,797		21
22	Employee Benefits & Payroll Taxes			349,260	349,260		349,260		349,260		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,347	9,347		9,347	288	9,635		24
25	Other Admin. Staff Transportation			10,356	10,356		10,356	3,408	13,764		25
26	Insurance-Prop.Liab.Malpractice			74,154	74,154		74,154	466	74,620		26
27	Other (specify):*							10,820	10,820		27
28	<b>TOTAL General Administration</b>	<b>163,909</b>	<b>35,962</b>	<b>785,668</b>	<b>985,539</b>		<b>985,539</b>	<b>(108,597)</b>	<b>876,942</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,185,084</b>	<b>382,438</b>	<b>998,539</b>	<b>3,566,061</b>		<b>3,566,061</b>	<b>(107,764)</b>	<b>3,458,297</b>		<b>29</b>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number COLONIAL HALL CARE CENTER #0049510 Report Period Beginning: 1/01/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation						64,422	64,422			30
31	Amortization of Pre-Op. & Org.						69	69			31
32	Interest			29,922	29,922	29,922	146,595	176,517			32
33	Real Estate Taxes			38,801	38,801	38,801		38,801			33
34	Rent-Facility & Grounds			276,232	276,232	276,232	(276,232)				34
35	Rent-Equipment & Vehicles			32,763	32,763	32,763	345	33,108			35
36	Other (specify):*						21,617	21,617			36
37	<b>TOTAL Ownership</b>			377,718	377,718	377,718	(43,184)	334,534			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			86,887	86,887	86,887		86,887			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			48,312	48,312	48,312		48,312			42
43	Other (specify):*						(27,531)	(27,531)			43
44	<b>TOTAL Special Cost Centers</b>			135,199	135,199	135,199	(27,531)	107,668			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,185,084	382,438	1,511,456	4,078,978	4,078,978	(178,479)	3,900,499			45

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

Facility Name & ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning: 1/01/08

Ending: 12/31/08

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,757)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(43)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,284)	21		18
19	Entertainment				19
20	Contributions	(3,414)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(84,280)	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	(33,377)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (129,155)</b>		<b>\$</b>	<b>30</b>

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)	(49,324)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (49,324)</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (178,479)</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS  
 COLONIAL HALL CARE CENTER

Report Period Beginning: 1/01/08  
 Ending: 12/31/08

ID# 0049510

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	ILLINOIS COUNCIL LTC-COPE	\$ (3,310)	20	1
2	VENDING REVENUE	(376)	21	2
3	MISCELLANEOUS INCOME	(12)	21	3
4	TAXES-GENERAL	(828)	21	4
5	MARKETING - SALARIES	(23,737)	43	5
6	MARKETING - EMPLOYEE BENEFITS	(3,794)	43	6
7	REAL ESTATE TAXES	(1,320)	33	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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36				36
37				37
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(33,377)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning:

1/01/08

Ending:

12/31/08

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,800)	0	0	0	0	0	0	0	0	0	0	(5,800)	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	3,060	0	0	0	0	0	0	0	0	3,060	5
6	Maintenance	0	0	3,573	0	0	0	0	0	0	0	0	3,573	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(5,800)</b>	<b>0</b>	<b>6,633</b>	<b>0</b>	<b>833</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(79,071)	0	0	0	0	0	0	0	0	(79,071)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	3,990	0	0	0	0	0	0	0	0	3,990	19
20	Fees, Subscriptions & Promotions	(87,590)	0	445	0	0	0	0	0	0	0	0	(87,145)	20
21	Clerical & General Office Expenses	(6,914)	0	45,561	0	0	0	0	0	0	0	0	38,647	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	288	0	0	0	0	0	0	0	0	288	24
25	Other Admin. Staff Transportation	0	0	3,408	0	0	0	0	0	0	0	0	3,408	25
26	Insurance-Prop.Liab.Malpractice	0	0	466	0	0	0	0	0	0	0	0	466	26
27	Other (specify):*	0	0	10,820	0	0	0	0	0	0	0	0	10,820	27
28	<b>TOTAL General Administration</b>	<b>(94,504)</b>	<b>0</b>	<b>(14,093)</b>	<b>0</b>	<b>(108,597)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(100,304)</b>	<b>0</b>	<b>(7,460)</b>	<b>0</b>	<b>(107,764)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning:

1/01/08

Ending:

12/31/08

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	0	62,975	1,447	0	0	0	0	0	0	0	0	64,422	30
31	Amortization of Pre-Op. & Org.	0	0	69	0	0	0	0	0	0	0	0	69	31
32	Interest	0	144,829	1,766	0	0	0	0	0	0	0	0	146,595	32
33	Real Estate Taxes	(1,320)	0	1,320	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(276,232)	0	0	0	0	0	0	0	0	0	(276,232)	34
35	Rent-Equipment & Vehicles	0	0	345	0	0	0	0	0	0	0	0	345	35
36	Other (specify):*	0	21,617	0	0	0	0	0	0	0	0	0	21,617	36
37	<b>TOTAL Ownership</b>	<b>(1,320)</b>	<b>(46,811)</b>	<b>4,947</b>	<b>0</b>	<b>(43,184)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(27,531)	0	0	0	0	0	0	0	0	0	0	(27,531)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(27,531)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(27,531)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(129,155)</b>	<b>(46,811)</b>	<b>(2,513)</b>	<b>0</b>	<b>(178,479)</b>	<b>45</b>							

Facility Name & ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning:

1/01/08

Ending:

12/31/08

**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
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

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	34 RENT	\$ 276,232	PHCH REALTY, LLC	100.00%	\$	\$ (276,232)	1
2	V	30 DEPRECIATION				62,975	62,975	2
3	V	32 INTEREST				144,829	144,829	3
4	V	36 AMORTIZATION-LOAN COSTS				21,617	21,617	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		\$ 276,232			\$ 229,421	\$ * (46,811)	14

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

Facility Name & ID Number COLONIAL HALL CARE CENTER# 0049510Report Period Beginning: 1/01/08Ending: 12/31/08

## 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	\$ 96,000	Platinum Health Care, LLC	100.00%	\$	\$ (96,000)	15
16	V	5 Utilities		Platinum Health Care, LLC		3,060	3,060	16
17	V	6 Repairs & Maintenance		Platinum Health Care, LLC		3,573	3,573	17
18	V	17 Administrative Salary		Platinum Health Care, LLC		16,929	16,929	18
19	V	19 Professional Fees		Platinum Health Care, LLC		3,990	3,990	19
20	V	20 Fees, Subscriptions		Platinum Health Care, LLC		445	445	20
21	V	21 Clerical Salaries		Platinum Health Care, LLC		40,597	40,597	21
22	V	21 Office Expenses		Platinum Health Care, LLC		4,964	4,964	22
23	V	24 Education & Seminars		Platinum Health Care, LLC		288	288	23
24	V	25 Travel		Platinum Health Care, LLC		3,408	3,408	24
25	V	26 Insurance		Platinum Health Care, LLC		466	466	25
26	V	27 Employee Benefits		Platinum Health Care, LLC		10,820	10,820	26
27	V	30 Depreciation		Platinum Health Care, LLC		421	421	27
28	V	35 Equipment Rental		Platinum Health Care, LLC		345	345	28
29	V	31 Amortization		Platinum Health Care, LLC		69	69	29
30	V	30 Depreciation		Platinum Health Care, LLC		1,026	1,026	30
31	V	32 Interest		Platinum Health Care, LLC		1,766	1,766	31
32	V	33 Real Estate Taxes		Platinum Health Care, LLC		1,320	1,320	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 96,000			\$ 93,487	\$ * (2,513)	39

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

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/01/08 Ending: 12/31/08

## 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	1.00	SEE ATTACHED	3	7.50	Mgt Fees	\$	1
2	Brian Levinson		Administrative	27.50	SEE ATTACHED	4	10.00	Mgt Fees		2
3	Mark Shapiro		Administrative	10.00	SEE ATTACHED	8	20.00	Mgt Fees		3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning:

1/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Platinum Health Care, LLC  
 Street Address 7444 Long Ave.  
 City / State / Zip Code Skokie, IL 60077  
 Phone Number ( 847 ) 329-4100  
 Fax Number ( 847 ) 329-7652

1	2	3	4	5	6	7	8	9	
Schedule V 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	522,253	12	\$ 54,883	\$ 29,120	\$ 3,060	1
2	6	Repairs & Maintenance	Patient Days	522,253	12	64,073	29,120	3,573	2
3	17	Administrative Salary	Patient Days	522,253	12	303,614	303,614	16,929	3
4	19	Professional Fees	Patient Days	522,253	12	71,566	29,120	3,990	4
5	20	Fees, Subscriptions	Patient Days	522,253	12	7,979	29,120	445	5
6	21	Clerical Salaries	Patient Days	522,253	12	728,090	728,090	40,597	6
7	21	Office Expenses	Patient Days	522,253	12	89,019	29,120	4,964	7
8	24	Education & Seminars	Patient Days	522,253	12	5,163	29,120	288	8
9	25	Travel	Patient Days	522,253	12	61,119	29,120	3,408	9
10	26	Insurance	Patient Days	522,253	12	8,354	29,120	466	10
11	27	Employee Benefits	Patient Days	522,253	12	194,056	29,120	10,820	11
12	30	Depreciation	Patient Days	522,253	12	7,547	29,120	421	12
13	35	Equipment Rental	Patient Days	522,253	12	6,184	29,120	345	13
14	31	Amortization	Patient Days	522,253	12	1,246	29,120	69	14
15	30	Depreciation	Patient Days	522,253	12	18,405	29,120	1,026	15
16	32	Interest	Patient Days	522,253	12	31,679	29,120	1,766	16
17	33	Real Estate Taxes	Patient Days	522,253	12	23,679	29,120	1,320	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,676,656	\$ 1,031,704	\$ 93,487	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	LASALLE BANK		X	MORTGAGE			\$	\$		\$ 144,829	1									
2											2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	LASALLE BANK		X	LINE OF CREDIT						29,922	6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>					\$	\$			\$ 174,751	9									
<b>B. Non-Facility Related*</b>																				
10											10									
11											11									
12											12									
13	ALLOCATION FROM PLATINUM									1,766	13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ 1,766	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ 176,517	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #         

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME COLONIAL HALL CARE CENTER COUNTY BUREAU

FACILITY IDPH LICENSE NUMBER 0049510

CONTACT PERSON REGARDING THIS REPORT DARRYL BUEKER

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

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(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. <u>16-15-303-020</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>37,001.80</u>	\$ <u>37,001.80</u>
2. <u>16-15-301-008</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>493.80</u>	\$ <u>493.80</u>
3. <u>16-15-301-009</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>493.80</u>	\$ <u>493.80</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>37,989.40</u>	\$ <u>37,989.40</u>

**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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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 CARE CENTER

# 0049510 Report Period Beginning:

1/01/08 Ending:

12/31/08

**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 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).

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name & ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning:

1/01/08

Ending:

12/31/08

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2007		\$ 1,038,400	\$ 37,760	27.5	\$ 37,760	\$	\$ 44,053	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		STORAGE SHED/SLAB		2007	2,241		15	149	149	174	9
10		INSTALL NEW HOT WATER HEATER		2008	5,500		10	550	550	550	10
11		INSTALL NEW CARPET-RESIDENT ROOM		2008	935		5	140	140	140	11
12		WEST & SOUTH WALL-PLASTER-VILLA'S CONCRETE		2008	8,000		12	500	500	500	12
13		2 BASES/SMOKE DETECTORS		2008	2,510		10	146	146	146	13
14		COACH LIGHTS BY WALK IN		2008	768		10	38	38	38	14
15		CEILING PLASTER REPAIR		2008	985		12	41	41	41	15
16		3 SMOKE DETECTORS		2008	504		10	25	25	25	16
17		REPLACE TWO HEAT		2008	1,160		10	58	58	58	17
18		2 LLCO PUSH BUTTON LOCKS		2008	624		10	31	31	31	18
19		INSTALL NE INTERIOR DOOR		2008	588		15	20	20	20	19
20		4 OAK DOORS		2008	2,071		15	58	58	58	20
21		1 18" HANDRAIL		2008	380		15	11	11	11	21
22		INSTALL POST LIGHT BY MAIN SIDELWALK-ELMORE ELECTRIC		2008	2,239		10	75	75	75	22
23		MAT/LABOR REMODEL LAUNRY SHOOT-A.M. REMODELERS-CO		2008	3,500		27.5	21	21	21	23
24		MAT/LABOR INSTALL CONCRETE SIDEWALK & HANDICAP GAT		2008	2,250		15	25	25	25	24
25						1,888			(1,888)		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	ALLOCATION FROM PLATINUM		470		470			67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,072,655	\$ 40,118		\$ 40,118	\$	\$ 45,966	70

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

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 173,492	\$ 22,620	\$ 22,620	\$		\$ 25,840	71
72	Current Year Purchases	16,968	707	707			707	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		977	977				74
75	TOTALS	\$ 190,460	\$ 24,304	\$ 24,304	\$		\$ 26,547	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				\$	\$	\$	\$		\$	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)	\$	1,263,115	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	64,422	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	64,422	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	72,513	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	<b>TOTAL</b>				\$ _____			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 32,763 Description: Medical \$21,985; Pinter/copier \$6,184; Postage \$2,105; Misc. 2,489

(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	<b>TOTAL</b>		\$ _____	\$ _____	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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	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	\$		\$	\$ 353		\$ 353	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			58,442			58,442	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				80,301		80,301	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Lab</u>						6,586		6,586	13
14	<b>TOTAL</b>			\$		\$ 58,442	\$ 87,240		\$ 145,682	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.

Facility Name &amp; ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning: 1/01/08

Ending:

12/31/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 5,745	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,185,067		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,612		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	(321,851)		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 929,573	\$	10
	<b>B. Long-Term Assets</b>			
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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 929,573	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 249,792	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	170,000		29
30	Accrued Salaries Payable	25,607		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,400		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accrued Expenses	21,743		36
37	Due Others, Adv Billing	165,204		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 670,746	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 670,746	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 258,827	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 929,573	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 74,524	1
2	Restatements (describe):		2
3	<b>ROUNDING</b>	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 74,525	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	184,302	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)	\$ 184,302	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 258,827	24 *

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

Facility Name &amp; ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning: 1/01/08

Ending: 12/31/08

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,381,446	1
2	Discounts and Allowances for all Levels	(115,309)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,266,137	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	778,165	6
7	Oxygen	69,895	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 848,060	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(11)	13
14	Non-Patient Meals	5,757	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	126,816	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,867	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	6,266	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 148,695	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Vending, Misc. Income</b>	388	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 388	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,263,280	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	694,026	31
32	Health Care	1,886,496	32
33	General Administration	985,539	33
<b>B. Capital Expense</b>			
34	Ownership	377,718	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	86,887	35
36	Provider Participation Fee	48,312	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,078,978	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	184,302	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 184,302	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. Tax Return 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.

Facility Name & ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning: 1/01/08

Ending:

12/31/08

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	2,106	2,469	\$ 75,387	\$ 30.53	1
2	Assistant Director of Nursing	2,018	2,480	65,587	26.45	2
3	Registered Nurses	14,137	15,430	398,827	25.85	3
4	Licensed Practical Nurses	11,240	11,970	233,556	19.51	4
5	CNAs & Orderlies	52,103	55,230	625,694	11.33	5
6	CNA Trainees					6
7	Licensed Therapist	2,418	2,469	104,311	42.25	7
8	Rehab/Therapy Aides	1,584	1,792	55,779	31.13	8
9	Activity Director	1,245	1,404	19,288	13.74	9
10	Activity Assistants	3,315	3,551	30,314	8.54	10
11	Social Service Workers	2,225	2,398	36,422	15.19	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,160	41,678	19.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,646	14,637	130,292	8.90	15
16	Dishwashers					16
17	Maintenance Workers	2,068	2,389	54,757	22.92	17
18	Housekeepers	10,330	11,171	94,164	8.43	18
19	Laundry	6,459	6,800	55,119	8.11	19
20	Administrator	1,733	2,160	87,068	40.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,155	6,071	76,841	12.66	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)	133,702	144,581	\$ 2,185,084 *	\$ 15.11	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	181	\$ 6,387	1-03	35
36	Medical Director	Monthly	6,058	9-03	36
37	Medical Records Consultant	Monthly	1,840	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,523	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	950	11-03	44
45	Social Service Consultant	76	4,727	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	276	\$ 23,485		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





**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 \$5,456
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,435 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,312  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? 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? N/A  
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? \_\_\_\_\_  
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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ 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 \$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.