



Facility Name & ID Number COLONIAL HALL CARE CENTER

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

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,120	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	15,839		5,055	20,894	8
9	SNF/PED					9
10	ICF		8,382		8,382	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,839	8,382	5,055	29,276	14

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

D. How many bed-hold days during this year were paid by the Department? NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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 4,292

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	219,840	6,283	10,316	236,439		236,439		236,439		1
2	Food Purchase		157,904		157,904		157,904	(9,235)	148,669		2
3	Housekeeping	97,708	17,975		115,683		115,683		115,683		3
4	Laundry	54,676	20,894		75,570		75,570		75,570		4
5	Heat and Other Utilities			108,044	108,044		108,044	1,616	109,660		5
6	Maintenance	58,416		69,143	127,559		127,559	2,376	129,935		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>430,640</b>	<b>203,056</b>	<b>187,503</b>	<b>821,199</b>		<b>821,199</b>	<b>(5,243)</b>	<b>815,956</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,500	4,500		4,500		4,500		9
10	Nursing and Medical Records	1,617,648	78,617	7,919	1,704,184		1,704,184		1,704,184		10
10a	Therapy	397,944	25,900	130,950	554,794		554,794		554,794		10a
11	Activities	63,188	8,100	7,534	78,822		78,822	(41)	78,781		11
12	Social Services	42,982		504	43,486		43,486		43,486		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,121,762</b>	<b>112,617</b>	<b>151,407</b>	<b>2,385,786</b>		<b>2,385,786</b>	<b>(41)</b>	<b>2,385,745</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	97,098		121,455	218,553		218,553	(113,211)	105,342		17
18	Directors Fees										18
19	Professional Services			246,183	246,183		246,183	(13,374)	232,809		19
20	Dues, Fees, Subscriptions & Promotions			62,893	62,893		62,893	(48,125)	14,768		20
21	Clerical & General Office Expenses	106,031	37,942	49,194	193,167		193,167	37,873	231,040		21
22	Employee Benefits & Payroll Taxes			548,036	548,036		548,036		548,036		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,680	10,680		10,680	19	10,699		24
25	Other Admin. Staff Transportation			37,074	37,074		37,074	2,692	39,766		25
26	Insurance-Prop.Liab.Malpractice			67,982	67,982		67,982	6,165	74,147		26
27	Other (specify):*							9,998	9,998		27
28	<b>TOTAL General Administration</b>	<b>203,129</b>	<b>37,942</b>	<b>1,143,497</b>	<b>1,384,568</b>		<b>1,384,568</b>	<b>(117,963)</b>	<b>1,266,605</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,755,531</b>	<b>353,615</b>	<b>1,482,407</b>	<b>4,591,553</b>		<b>4,591,553</b>	<b>(123,247)</b>	<b>4,468,306</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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			38	38		38	86,622	86,660			30
31	Amortization of Pre-Op. & Org.							122	122			31
32	Interest			70,402	70,402		70,402	123,677	194,079			32
33	Real Estate Taxes			41,656	41,656		41,656	651	42,307			33
34	Rent-Facility & Grounds			292,764	292,764		292,764	(292,764)				34
35	Rent-Equipment & Vehicles			57,209	57,209		57,209	(7,131)	50,078			35
36	Other (specify):*							4,658	4,658			36
37	<b>TOTAL Ownership</b>			462,069	462,069		462,069	(84,165)	377,904			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			167,397	167,397		167,397		167,397			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			215,577	215,577		215,577		215,577			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,755,531	353,615	2,160,053	5,269,199		5,269,199	(207,412)	5,061,787			45

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

**VI. ADJUSTMENT DETAIL**

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

		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	(9,213)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,921)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(22)	2		13
14	Non-Care Related Interest	(55,501)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(46,339)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,498)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,529)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (129,523)		\$	30

**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)	(77,889)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (77,889)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (207,412)		37

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

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

		1	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>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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COLONIAL HALL CARE CENTER

ID# 0049510

Report Period Beginning: 1/1/11

Ending: 12/31/11

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

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning:

1/1/11

Ending:

12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,235)	0	0	0	0	0	0	0	0	0	0	(9,235)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,616	0	0	0	0	0	0	0	0	1,616	5
6	Maintenance	0	0	2,376	0	0	0	0	0	0	0	0	2,376	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(9,235)</b>	<b>0</b>	<b>3,992</b>	<b>0</b>	<b>(5,243)</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	(41)	0	0	0	0	0	0	0	0	0	0	(41)	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>(41)</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>(41)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(113,211)	0	0	0	0	0	0	0	0	(113,211)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(16,040)	2,666	0	0	0	0	0	0	0	0	(13,374)	19
20	Fees, Subscriptions & Promotions	(48,501)	0	376	0	0	0	0	0	0	0	0	(48,125)	20
21	Clerical & General Office Expenses	(7,533)	0	45,406	0	0	0	0	0	0	0	0	37,873	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	19	0	0	0	0	0	0	0	0	19	24
25	Other Admin. Staff Transportation	0	0	2,692	0	0	0	0	0	0	0	0	2,692	25
26	Insurance-Prop.Liab.Malpractice	0	6,764	(599)	0	0	0	0	0	0	0	0	6,165	26
27	Other (specify):*	0	0	9,998	0	0	0	0	0	0	0	0	9,998	27
28	<b>TOTAL General Administration</b>	<b>(56,034)</b>	<b>(9,276)</b>	<b>(52,653)</b>	<b>0</b>	<b>(117,963)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(65,310)</b>	<b>(9,276)</b>	<b>(48,661)</b>	<b>0</b>	<b>(123,247)</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning:

1/1/11

Ending:

12/31/11

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	2,909	82,077	1,636	0	0	0	0	0	0	0	0	86,622	30
31	Amortization of Pre-Op. & Org.	0	0	122	0	0	0	0	0	0	0	0	122	31
32	Interest	(59,422)	182,073	1,026	0	0	0	0	0	0	0	0	123,677	32
33	Real Estate Taxes	0	0	651	0	0	0	0	0	0	0	0	651	33
34	Rent-Facility & Grounds	0	(292,764)	0	0	0	0	0	0	0	0	0	(292,764)	34
35	Rent-Equipment & Vehicles	(7,700)	0	569	0	0	0	0	0	0	0	0	(7,131)	35
36	Other (specify):*	0	4,658	0	0	0	0	0	0	0	0	0	4,658	36
37	<b>TOTAL Ownership</b>	<b>(64,213)</b>	<b>(23,956)</b>	<b>4,004</b>	<b>0</b>	<b>(84,165)</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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</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>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(129,523)	(33,232)	(44,657)	0	0	0	0	0	0	0	0	(207,412)	45

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		SEE PG6-SUPP				

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 HOME OFFICE	\$ 121,455	PLATINUM HEALTH CARE, LLC	100.00%	\$	\$ (121,455)
16	V	5 Utilities		PLATINUM HEALTH CARE, LLC		1,616	1,616
17	V	6 Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		2,376	2,376
18	V	17 Administrative Salary		PLATINUM HEALTH CARE, LLC		8,244	8,244
19	V	19 Professional Fees		PLATINUM HEALTH CARE, LLC		2,666	2,666
20	V	20 Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		376	376
21	V	21 Clerical Salaries		PLATINUM HEALTH CARE, LLC		41,222	41,222
22	V	21 Office Expenses		PLATINUM HEALTH CARE, LLC		4,184	4,184
23	V	24 Education & Seminars		PLATINUM HEALTH CARE, LLC		19	19
24	V	25 Travel		PLATINUM HEALTH CARE, LLC		2,692	2,692
25	V	26 Insurance		PLATINUM HEALTH CARE, LLC		(599)	(599)
26	V	27 Employee Benefits		PLATINUM HEALTH CARE, LLC		9,998	9,998
27	V	30 Depreciation		PLATINUM HEALTH CARE, LLC		1,021	1,021
28	V	35 Equipment Rental		PLATINUM HEALTH CARE, LLC		569	569
29	V	31 Amortization		PLATINUM HEALTH CARE, LLC		122	122
30	V	30 Depreciation		PLATINUM HEALTH CARE, LLC		615	615
31	V	32 Interest		PLATINUM HEALTH CARE, LLC		1,026	1,026
32	V	33 Real Estate Taxes		PLATINUM HEALTH CARE, LLC		651	651
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 121,455			\$ 76,798	\$ * (44,657)

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



Facility Name &amp; ID Number

COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning:

1/1/11

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12/31/11

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	BEN KLEIN		Administrative	4.34	SEE ATTACHED	1	3.45	Mgt Fees	\$	1
2	BRIAN LEVINSON		Administrative	30.83	SEE ATTACHED	4	10.00	Mgt Fees		2
3	MARK SHAPIRO		Administrative	13.33	SEE ATTACHED	4	10.00	Mgt Fees		3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number COLONIAL HALL CARE CENTER

# 0049510

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V 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	876,273	29	\$ 48,379	\$ 29,276	\$ 1,616	1
2	6	Repairs & Maintenance	Patient Days	876,273	29	71,131	29,276	2,376	2
3	17	Administrative Salary	Patient Days	876,273	29	246,751	246,751	8,244	3
4	19	Professional Fees	Patient Days	876,273	29	79,792	29,276	2,666	4
5	20	Fees, Subscriptions	Patient Days	876,273	29	11,255	29,276	376	5
6	21	Clerical Salaries	Patient Days	876,273	29	1,233,841	1,233,841	41,222	6
7	21	Office Expenses	Patient Days	876,273	29	125,226	29,276	4,184	7
8	24	Education & Seminars	Patient Days	876,273	29	577	29,276	19	8
9	25	Travel	Patient Days	876,273	29	80,576	29,276	2,692	9
10	26	Insurance	Patient Days	876,273	29	(17,938)	29,276	(599)	10
11	27	Employee Benefits	Patient Days	876,273	29	299,243	29,276	9,998	11
12	30	Depreciation	Patient Days	876,273	29	30,566	29,276	1,021	12
13	35	Equipment Rental	Patient Days	876,273	29	17,025	29,276	569	13
14	31	Amortization	Patient Days	876,273	29	3,657	29,276	122	14
15	30	Depreciation	Patient Days	876,273	29	18,405	29,276	615	15
16	32	Interest	Patient Days	876,273	29	30,718	29,276	1,026	16
17	33	Real Estate Taxes	Patient Days	876,273	29	19,475	29,276	651	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,298,679	\$ 1,480,592	\$ 76,798	25

Facility Name & ID Number

COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning:

1/1/11

Ending:

12/31/11

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**		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	HUD LOAN		X	MORTGAGE						\$ 182,073	1								
2											2								
3											3								
4											4								
5											5								
<b>Working Capital</b>																			
6			X	LINE OF CREDIT						14,901	6								
7											7								
8											8								
9	TOTAL Facility Related						\$	\$		\$ 196,974	9								
<b>B. Non-Facility Related*</b>																			
10	INTEREST INCOME OFFSET									(3,921)	10								
11											11								
12											12								
13	ALLOCATION FROM PLATINUM									1,026	13								
14	TOTAL Non-Facility Related						\$	\$		\$ (2,895)	14								
15	TOTALS (line 9+line14)						\$	\$		\$ 194,079	15								

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

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2010 report.		\$	<b>84,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>63,256</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(20,744)</b>	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>62,400</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>41,656</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2006		<b>8</b>	
	2007	<b>37,989</b>	<b>9</b>	
	2008	<b>60,687</b>	<b>10</b>	
	2009	<b>61,605</b>	<b>11</b>	
	2010	<b>63,256</b>	<b>12</b>	
	<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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



Facility Name & ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning:

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,295 B. General Construction Type: Exterior BRICK Frame Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Land. Row 2: 1. Row 3: 2. Row 4: 3 TOTALS

Facility Name &amp; ID Number COLONIAL HALL CARE CENTER

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Report Period Beginning:

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

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

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number COLONIAL HALL CARE CENTER

# 0049510

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## XI. OWNERSHIP COSTS (continued)

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

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 261,565	\$ 20,076	\$ 23,892	\$ 3,816		\$ 105,607	71
72	Current Year Purchases	73,196	1,920	1,920			20,076	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		1,174	1,174				74
75	TOTALS	\$ 334,761	\$ 23,170	\$ 26,986	\$ 3,816		\$ 125,683	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

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

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  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

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: \$ 57,209 Description: Medical equip \$32,182; printers/copiers \$22,837; postage \$1,656; misc \$534

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

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

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

**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>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		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	\$		\$				1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		1,984	130,950	25,900	1,984	156,850	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescripts				124,992		124,992	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <b>Lab &amp; X-ray</b>	39-02					42,405		42,405	13
14	<b>TOTAL</b>			\$	1,984	\$ 130,950	\$ 193,297	1,984	\$ 324,247	14

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

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/11**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (14,511)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,605,240		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,974		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,705,703	\$	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	7,223		15
16	Equipment, at Historical Cost	45,741		16
17	Accumulated Depreciation (book methods)	(51,995)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 969	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,706,672	\$	25

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

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>410,398</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>2</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>410,400</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>485,037</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(390,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>95,037</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>505,437</b>	<b>24</b> *

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

Facility Name &amp; ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning: 1/1/11

Ending: 12/31/11

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	\$ 4,207,856	1
2	Discounts and Allowances for all Levels	(237,730)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,970,126	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,501,523	6
7	Oxygen	63,690	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,565,213	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	870	13
14	Non-Patient Meals	9,213	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	165,565	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,136	19
20	Radiology and X-Ray	18,451	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 207,235	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,921	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,921	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>TRANSPORTATION &amp; MISC INCOME</b>	7,741	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 7,741	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,754,236	30

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

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

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

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

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

Facility Name & ID Number **COLONIAL HALL CARE CENTER**

# **0049510**

Report Period Beginning:

1/1/11

Ending:

12/31/11

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,959	2,254	\$ 79,507	\$ 35.27	1
2	Assistant Director of Nursing	1,916	2,177	70,518	32.39	2
3	Registered Nurses	16,854	18,140	486,329	26.81	3
4	Licensed Practical Nurses	11,539	12,164	258,829	21.28	4
5	CNAs & Orderlies	56,903	60,006	722,465	12.04	5
6	CNA Trainees					6
7	Licensed Therapist	3,886	4,225	194,917	46.13	7
8	Rehab/Therapy Aides	5,539	6,161	203,027	32.95	8
9	Activity Director	1,896	2,072	29,293	14.14	9
10	Activity Assistants	3,547	3,825	33,895	8.86	10
11	Social Service Workers	3,078	3,321	42,982	12.94	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,071	37,889	18.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,779	19,355	181,951	9.40	15
16	Dishwashers					16
17	Maintenance Workers	1,938	2,174	58,416	26.87	17
18	Housekeepers	10,131	10,386	97,708	9.41	18
19	Laundry	5,619	5,812	54,676	9.41	19
20	Administrator	1,762	2,081	97,098	46.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,822	8,179	106,031	12.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,152	164,403	\$ 2,755,531 *	\$ 16.76	34

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

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number COLONIAL HALL CARE CENTER

Report Period Beginning: 1/1/11

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
LOUANNE KENWICK	ADMINISTRATOR		\$ 97,098	Workers' Compensation Insurance	\$ 160,147	IDPH License Fee	\$	
				Unemployment Compensation Insurance	54,184	Advertising: Employee Recruitment	2,098	
				FICA Taxes	204,491	Health Care Worker Background Check	2,559	
				Employee Health Insurance	88,523	(Indicate # of checks performed 13 )		
				Employee Meals		Patient Background Checks	139	
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING & MARKETING	46,339	
				401K	1,100	DUES & SUBSCRIPTIONS	8,253	
				EMPLOYEE BENEFITS - OTHER	39,591	LICENSES	1,482	
				EMPLOYEE PHYSICAL EXAM				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 97,098			ALLOCATION FROM PLATINUM	376	
B. Administrative - Other						Less: Public Relations Expense	( )	
Description			Amount			Non-allowable advertising	(46,339)	
			\$			Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 548,036	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,768	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
SEE ATTACHED SCHEDULE			\$ 246,183			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	10,680
							ALLOCATION FROM PLATINUM	19
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 246,183	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 10,699

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number COLONIAL HALL CARE CENTER

# 0049510

Report Period Beginning: 1/1/11

Ending: 12/31/11

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL COUNCIL LTC \$8,712
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,099 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,180  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? YES  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? \_\_\_\_\_ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**g. Does the facility transport residents to and from day training? \_\_\_\_\_**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.