FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0049510

Facility Name: COLONIAL HALL CARE CENTER

Address: 515 BUREAU VALLEY PARKWAY (Number) PRINCETON (City) 61356 (Zip Code)

County: BUREAU

Telephone Number: (815) 875-3347 **Fax #** (815) 875-2012

HFS ID Number:

Date of Initial License for Current Owners: 5/1/07

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DARRYL BUEKER **Telephone Number:** (417) 865-8701
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) DARRYL BUEKER, CPA, PARTNER
(Firm Name & Address) BKD, LLP, P. O. BOX 1190, SPRINGFIELD, MO 65801-1190
(Telephone) (417) 865-8701 Fax # (417) 865-0682

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,042		4,955	19,997	8
9	SNF/PED					9
10	ICF		7,923		7,923	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,042	7,923	4,955	27,920	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.92%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/07

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 88 and days of care provided 4,225

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	200,788	10,474	9,815	221,077		221,077		221,077			1
2	Food Purchase		139,754		139,754		139,754	(8,600)	131,154			2
3	Housekeeping	91,855	18,557		110,412		110,412		110,412			3
4	Laundry	60,592	22,436		83,028		83,028		83,028			4
5	Heat and Other Utilities			90,131	90,131		90,131	2,501	92,632			5
6	Maintenance	57,212		60,750	117,962		117,962	2,346	120,308			6
7	Other (specify):*											7
8	TOTAL General Services	410,447	191,221	160,696	762,364		762,364	(3,753)	758,611			8
	B. Health Care and Programs											
9	Medical Director			7,000	7,000		7,000		7,000			9
10	Nursing and Medical Records	1,524,170	88,528	6,723	1,619,421		1,619,421		1,619,421			10
10a	Therapy	310,042	12,065	58,080	380,187		380,187		380,187			10a
11	Activities	63,831	4,788	9,652	78,271		78,271		78,271			11
12	Social Services	34,699		1,388	36,087		36,087		36,087			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,932,742	105,381	82,843	2,120,966		2,120,966		2,120,966			16
	C. General Administration											
17	Administrative	108,450		98,880	207,330		207,330	(89,328)	118,002			17
18	Directors Fees											18
19	Professional Services			189,151	189,151		189,151	(760)	188,391			19
20	Dues, Fees, Subscriptions & Promotions			52,459	52,459		52,459	(39,783)	12,676			20
21	Clerical & General Office Expenses	101,211	40,371	43,050	184,632		184,632	50,451	235,083			21
22	Employee Benefits & Payroll Taxes			410,462	410,462		410,462		410,462			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,925	12,925		12,925	221	13,146			24
25	Other Admin. Staff Transportation			30,335	30,335		30,335	3,161	33,496			25
26	Insurance-Prop.Liab.Malpractice			65,591	65,591		65,591	323	65,914			26
27	Other (specify):*							7,087	7,087			27
28	TOTAL General Administration	209,661	40,371	902,853	1,152,885		1,152,885	(68,628)	1,084,257			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,552,850	336,973	1,146,392	4,036,215		4,036,215	(72,381)	3,963,834			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number COLONIAL HALL CARE CENTER #0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			15,983	15,983		15,983	59,412	75,395			30
31	Amortization of Pre-Op. & Org.							176	176			31
32	Interest			3,771	3,771		3,771	193,320	197,091			32
33	Real Estate Taxes			84,405	84,405		84,405	840	85,245			33
34	Rent-Facility & Grounds			297,085	297,085		297,085	(297,085)				34
35	Rent-Equipment & Vehicles			30,721	30,721		30,721	131	30,852			35
36	Other (specify):*							4,658	4,658			36
37	**TOTAL Ownership**			431,965	431,965		431,965	(38,548)	393,417			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			126,090	126,090		126,090		126,090			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,180	48,180		48,180		48,180			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			174,270	174,270		174,270		174,270			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,552,850	336,973	1,752,627	4,642,450		4,642,450	(110,929)	4,531,521			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: 1/1/10 Ending: 12/31/10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,570)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,412)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(30)	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	(15)	21		18
19	Entertainment				19
20	Contributions	(4,395)	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	(37,282)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax		21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(17,904)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (70,608)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(40,321)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (40,321)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (110,929)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

COLONIAL HALL CARE CENTER

ID# 0049510

Report Period Beginning: 1/1/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL LTC - COPE	$ (3,222)	20	1
2	MISCELLANEOUS INCOME	(745)	21	2
3	TAXES - GENERAL	(362)	21	3
4	ADJUST S/L DEPR	(13,575)	30	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(17,904)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COLONIAL HALL CARE CENTER **#** 0049510 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,600)	0	0	0	0	0	0	0	0	0	0	(8,600)	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	2,501	0	0	0	0	0	0	0	0	2,501	5
6	Maintenance	0	0	2,346	0	0	0	0	0	0	0	0	2,346	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,600)	0	4,847	0	0	0	0	0	0	0	0	(3,753)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(89,328)	0	0	0	0	0	0	0	0	(89,328)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(4,640)	3,880	0	0	0	0	0	0	0	0	(760)	19
20	Fees, Subscriptions & Promotions	(40,504)	0	721	0	0	0	0	0	0	0	0	(39,783)	20
21	Clerical & General Office Expenses	(5,517)	0	55,968	0	0	0	0	0	0	0	0	50,451	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	221	0	0	0	0	0	0	0	0	221	24
25	Other Admin. Staff Transportation	0	0	3,161	0	0	0	0	0	0	0	0	3,161	25
26	Insurance-Prop.Liab.Malpractice	0	0	323	0	0	0	0	0	0	0	0	323	26
27	Other (specify):*	0	0	7,087	0	0	0	0	0	0	0	0	7,087	27
28	**TOTAL General Administration**	(46,021)	(4,640)	(17,967)	0	0	0	0	0	0	0	0	(68,628)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(54,621)	(4,640)	(13,120)	0	0	0	0	0	0	0	0	(72,381)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COLONIAL HALL CARE CENTER **#** 0049510 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(13,575)	71,430	1,557	0	0	0	0	0	0	0	0	59,412	30
31	Amortization of Pre-Op. & Org.	0	0	176	0	0	0	0	0	0	0	0	176	31
32	Interest	(2,412)	194,237	1,495	0	0	0	0	0	0	0	0	193,320	32
33	Real Estate Taxes	0	0	840	0	0	0	0	0	0	0	0	840	33
34	Rent-Facility & Grounds	0	(297,085)	0	0	0	0	0	0	0	0	0	(297,085)	34
35	Rent-Equipment & Vehicles	0	0	131	0	0	0	0	0	0	0	0	131	35
36	Other (specify):*	0	4,658	0	0	0	0	0	0	0	0	0	4,658	36
37	**TOTAL Ownership**	(15,987)	(26,760)	4,199	0	0	0	0	0	0	0	0	(38,548)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(70,608)	(31,400)	(8,921)	0	0	0	0	0	0	0	0	(110,929)	45

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 297,085	PHCH REALTY, LLC		$	$ (297,085)	1
2	V	30	DEPRECIATION				71,430	71,430	2
3	V	32	INTEREST				194,237	194,237	3
4	V	36	AMORTIZATION-LOAN COSTS				4,658	4,658	4
5	V								5
6	V								6
7	V	19	PROFESSIONAL FEES	85,000	PHC CONSULTANTS, LLC		80,360	(4,640)	7
8	V								8
9	V	19	PROFESSIONAL FEES	2,572	MTS CONSULTING		2,572		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 384,657			$ 353,257	$ * (31,400)	14

*** 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: 1/1/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	HOME OFFICE	$ 98,880	PLATINUM HEALTH CARE, LLC	100.00%	$	$ (98,880)	15
16	V	5	Utilities		PLATINUM HEALTH CARE, LLC		2,501	2,501	16
17	V	6	Repairs & Maintenance		PLATINUM HEALTH CARE, LLC		2,346	2,346	17
18	V	17	Administrative Salary		PLATINUM HEALTH CARE, LLC		9,552	9,552	18
19	V	19	Professional Fees		PLATINUM HEALTH CARE, LLC		3,880	3,880	19
20	V	20	Fees, Subscriptions		PLATINUM HEALTH CARE, LLC		721	721	20
21	V	21	Clerical Salaries		PLATINUM HEALTH CARE, LLC		49,463	49,463	21
22	V	21	Office Expenses		PLATINUM HEALTH CARE, LLC		6,505	6,505	22
23	V	24	Education & Seminars		PLATINUM HEALTH CARE, LLC		221	221	23
24	V	25	Travel		PLATINUM HEALTH CARE, LLC		3,161	3,161	24
25	V	26	Insurance		PLATINUM HEALTH CARE, LLC		323	323	25
26	V	27	Employee Benefits		PLATINUM HEALTH CARE, LLC		7,087	7,087	26
27	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		673	673	27
28	V	35	Equipment Rental		PLATINUM HEALTH CARE, LLC		131	131	28
29	V	31	Amortization		PLATINUM HEALTH CARE, LLC		176	176	29
30	V	30	Depreciation		PLATINUM HEALTH CARE, LLC		884	884	30
31	V	32	Interest		PLATINUM HEALTH CARE, LLC		1,495	1,495	31
32	V	33	Real Estate Taxes		PLATINUM HEALTH CARE, LLC		840	840	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 98,880			$ 89,959	$ * (8,921)	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: 1/1/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BEN KLEIN		Administrative	4.30	SEE ATTACHED	2	6.45	Mgt Fees	$		1
2	BRIAN LEVINSON		Administrative	30.83	SEE ATTACHED	6	15.00	Mgt Fees			2
3	MARK SHAPIRO		Administrative	13.33	SEE ATTACHED	4	10.00	Mgt Fees			3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	581,243	18	$ 52,068	$	27,920	$ 2,501	1
2	6	Repairs & Maintenance	Patient Days	581,243	18	48,848		27,920	2,346	2
3	17	Administrative Salary	Patient Days	581,243	18	198,854	198,854	27,920	9,552	3
4	19	Professional Fees	Patient Days	581,243	18	80,779		27,920	3,880	4
5	20	Fees, Subscriptions	Patient Days	581,243	18	15,003		27,920	721	5
6	21	Clerical Salaries	Patient Days	581,243	18	1,029,725	1,029,725	27,920	49,463	6
7	21	Office Expenses	Patient Days	581,243	18	135,424		27,920	6,505	7
8	24	Education & Seminars	Patient Days	581,243	18	4,602		27,920	221	8
9	25	Travel	Patient Days	581,243	18	65,815		27,920	3,161	9
10	26	Insurance	Patient Days	581,243	18	6,717		27,920	323	10
11	27	Employee Benefits	Patient Days	581,243	18	147,536		27,920	7,087	11
12	30	Depreciation	Patient Days	581,243	18	14,004		27,920	673	12
13	35	Equipment Rental	Patient Days	581,243	18	2,729		27,920	131	13
14	31	Amortization	Patient Days	581,243	18	3,657		27,920	176	14
15	30	Depreciation	Patient Days	581,243	18	18,405		27,920	884	15
16	32	Interest	Patient Days	581,243	18	31,121		27,920	1,495	16
17	33	Real Estate Taxes	Patient Days	581,243	18	17,492		27,920	840	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,872,779	$ 1,228,579		$ 89,959	25

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD LOAN		X	MORTGAGE			$	$			$ 194,237	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK OF AMERICA		X	LINE OF CREDIT							3,771	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 198,008	9
	B. Non-Facility Related*											
10	INTEREST INCOME OFFSET										(2,412)	10
11												11
12												12
13	ALLOCATION FROM PLATINUM										1,495	13
14	TOTAL Non-Facility Related						$	$			$ (917)	14
15	TOTALS (line 9+line14)						$	$			$ 197,091	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 25,342 **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.)**

Facility Name & ID Number COLONIAL HALL CARE CENTER **#** 0049510 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 61,200	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.)		$ 61,605	2
3. Under or (over) accrual (line 2 minus line 1).		$ 405	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 84,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 84,405	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	34,362	8
2006		9
2007	37,989	10
2008	60,687	11
2009	61,605	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-15-303-020	LONG TERM CARE PROPERTY	$ 60,574.56	$ 60,574.56
2.	16-15-301-008	LONG TERM CARE PROPERTY	$ 515.12	$ 515.12
3.	16-15-301-009	LONG TERM CARE PROPERTY	$ 515.12	$ 515.12
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,604.80	$ 61,604.80

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 1/1/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	$	$ 119,573	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	STORAGE SHED/SLAB (REMOVED $2,241 PER 2010 CAP COST DES			2007			15				9
10	INSTALL NEW HOT WATER HEATER			2008	5,500		10	550	550	1,650	10
11	INSTALL NEW CARPET-RESIDENT ROOM (REMOVED $935 PER 2			2008			5				11
12	WEST & SOUTH WALL-PLASTER-VILLA'S CONCRETE			2008	8,000		12	667	667	1,834	12
13	2 BASES/SMOKE DETECTORS			2008	2,510		10	251	251	648	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 CO			2008			15				19
20	4 OAK DOORS (REMOVED $2,071 PER 2010 CAP COST DESK AUDIT			2008			15				20
21	1 18" HANDRAIL (REMOVED $380 PER 2010 CAP COST DESK AUD			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	275	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	288	27
28	PORCH DEMOLITION/REMOVAL (REMOVED $2,286 PER 2010 CAP			2009			15				28
29	SPRINKLER SYSTEM			2009	11,000		25	440	440	623	29
30	FIRE PROTECTION SYSTEM			2010	133,759		25	3,121	3,121	3,121	30
31	LANDSCAPING-CONTRACT-PRINCETON LAWN CARE			2010	4,341		10	109	109	109	31
32	REPLACE ROOF			2010	58,500		27.5	532	532	532	32
33	AWNING SIDE ENTRY			2010	3,700		15	62	62	62	33
34	CERAMIC TILES 7 ENTRANCES/KITCHEN-CONTRACT-A.M. REM			2010	65,870		20	549	549	549	34
35	ASPHALT MAIN PARKING AREA			2010	31,240		8	651	651	651	35
36						8,833					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 & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	38" RED CEDAR DUMPSTER ENCLOSURE	2009	$ 2,673	$	8	$ 334	$ 334	$ 445	37
38	CONCRETE REPAIR (REMOVED $1,050 PER 2010 CAP COST	2009			15				38
39	SPRINKLER SYSTEM	2009	3,500		25	140	140	12	39
40	BUILT SOFFITS OVER SPRINKLERS-CONTRACT-A.M. REM	2010	6,500		25	152	152	152	40
41				6,538			(6,538)		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	ALLOCATION FROM PLATINUM			672		672			66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,381,582	$ 53,803		$ 46,290	$ 1,320	$ 130,524	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: 1/1/10 Ending: 12/31/10

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	$ 234,727	$ 23,830	$ 26,787	$ 2,957		$ 80,282	71
72	Current Year Purchases	26,839	10,452	1,433	(9,019)		1,433	72
73	Fully Depreciated Assets							73
74	Allocation from Platinum		885	885				74
75	TOTALS	$ 261,566	$ 35,167	$ 29,105	$ (6,062)		$ 81,715	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)	$ 1,643,148	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 88,970	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 75,395	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,575)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 212,239	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.

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ $30,721 Description: Medical $16,189; Printers/copiers $12,376; Postage $1,688; Misc $468
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe 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.

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-03	hrs		880	58,080		880	58,080	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				107,465		107,465	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab and X-ray	39-02					18,625		18,625	13
14	TOTAL			$	880	$ 58,080	$ 126,090	880	$ 184,170	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.

STATE OF ILLINOIS

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (21,010)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	887,640		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,802		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 935,432	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	7,223		15
16	Equipment, at Historical Cost	45,741		16
17	Accumulated Depreciation (book methods)	(51,957)		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): Due Others	(140,494)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ (139,487)	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 795,945	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 90,703	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	42,302		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	35,117		36
37	Due Other & Adv Billing	133,425		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 385,547	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 385,547	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 410,398	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 795,945	$	48

*(See instructions.)

Facility Name & ID Number COLONIAL HALL CARE CENTER **#** 0049510 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 347,673	1
2	Restatements (describe):		2
3	**Prior Period Adjustment-Rent & Depr**	(55,461)	3
4	**Rounding**	1	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 292,213	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	518,185	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	(400,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 118,185	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 410,398	24 *

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

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,827,265	1
2	Discounts and Allowances for all Levels	(255,420)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,571,845	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,317,645	6
7	Oxygen	64,856	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,382,501	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(77)	13
14	Non-Patient Meals	8,570	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	178,839	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,919	19
20	Radiology and X-Ray	7,881	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 203,132	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,412	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,412	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISC INCOME	745	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 745	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,160,635	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	762,364	31
32	Health Care	2,120,966	32
33	General Administration	1,152,885	33
	B. Capital Expense		
34	Ownership	431,965	34
	C. Ancillary Expense		
35	Special Cost Centers	126,090	35
36	Provider Participation Fee	48,180	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,642,450	40
41	**Income before Income Taxes (line 30 minus line 40)****	518,185	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 518,185	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: 1/1/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,056	2,325	$ 79,430	$ 34.16	1
2	Assistant Director of Nursing	2,015	2,211	69,854	31.59	2
3	Registered Nurses	16,116	17,457	458,507	26.26	3
4	Licensed Practical Nurses	11,359	12,025	252,876	21.03	4
5	CNAs & Orderlies	51,707	55,479	663,503	11.96	5
6	CNA Trainees					6
7	Licensed Therapist	4,765	4,985	196,715	39.46	7
8	Rehab/Therapy Aides	3,125	3,498	113,327	32.40	8
9	Activity Director	1,164	1,435	20,792	14.49	9
10	Activity Assistants	4,494	4,700	43,039	9.16	10
11	Social Service Workers	2,309	2,468	34,699	14.06	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,002	38,276	19.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,281	17,026	162,512	9.54	15
16	Dishwashers					16
17	Maintenance Workers	2,017	2,256	57,212	25.36	17
18	Housekeepers	9,460	10,175	91,855	9.03	18
19	Laundry	5,989	6,300	60,592	9.62	19
20	Administrator	1,972	2,243	108,450	48.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,639	7,975	101,211	12.69	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)	144,428	154,560	$ 2,552,850 *	$ 16.52	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	204	$ 9,815	1-03	35
36	Medical Director	Monthly	7,000	9-03	36
37	Medical Records Consultant	Quarterly	1,840	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,883	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	800	11-03	44
45	Social Service Consultant	22	1,388	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	242	$ 25,726		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LOUANNE KENWICK	ADMINISTRATOR		$ 108,450
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,450

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED SCHEDULE		$ 189,151
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 189,151

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,231
Unemployment Compensation Insurance	25,645
FICA Taxes	185,713
Employee Health Insurance	80,801
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	400
EMPLOYEE BENEFITS-OTHER	12,672
EMPLOYEE PHYSICAL EXAM	
TOTAL (agree to Schedule V, line 22, col.8)	$ 410,462

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	106
Health Care Worker Background Check	2,092
(Indicate # of checks performed 15)	
Patient Background Checks 148	
ADVERTISING & MARKETING	37,282
DUES & SUBSCRIPTIONS	6,652
LICENSES	3,105
ALLOCATION FROM PLATINUM	721
Less: Public Relations Expense	( )
Non-allowable advertising	(37,282)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,676

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	12,925
ALLOCATION FROM PLATINUM	221
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,146

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COLONIAL HALL CARE CENTER # 0049510 Report Period Beginning: 1/1/10 Ending: 12/31/10

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

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

Facility Name & ID Number COLONIAL HALL CARE CENTER **#** 0049510 **Report Period Beginning:** 1/1/10 **Ending:** 12/31/10

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 $7,656**

(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. $ **17,120** 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? **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?
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.