		FOR BHF USE					

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

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

I. IDPH License ID Number: 0042168

Facility Name: Colonial Manor

Address: 620 Warrington Avenue (Number) Danville (City) 61832 (Zip Code)

County: Vermillion

Telephone Number: (217) 446-0660 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 1996

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135
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 1-01-10 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) Craig L. Ater
(Title) Exec V.P. & CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 Manor # 0042168 Report Period Beginning: 1-01-10 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	83	Skilled (SNF)	83	30,295	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	83	TOTALS	83	30,295	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	9,602	11,837	5,677	27,116	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,602	11,837	5,677	27,116	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.51%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 1996

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified _____ and days of care provided 5,677

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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	264,803	14,809		279,612		279,612	3,308	282,920			1
2	Food Purchase		172,827		172,827		172,827	(781)	172,046			2
3	Housekeeping	129,872	41,810		171,682		171,682		171,682			3
4	Laundry	71,096	9,189		80,285		80,285		80,285			4
5	Heat and Other Utilities			109,997	109,997		109,997	1,429	111,426			5
6	Maintenance	98,846	125,980	80,465	305,291		305,291	9,849	315,140			6
7	Other (specify):*											7
8	TOTAL General Services	564,617	364,615	190,462	1,119,694		1,119,694	13,805	1,133,499			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400	2,430	10,830			9
10	Nursing and Medical Records	1,745,678	168,199	7,728	1,921,605		1,921,605		1,921,605			10
10a	Therapy		489,504	698,813	1,188,317	(546,508)	641,809	6,257	648,066			10a
11	Activities	72,447	7,040		79,487		79,487	3	79,490			11
12	Social Services	47,377		3,866	51,243		51,243		51,243			12
13	CNA Training							1,097	1,097			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,865,502	664,743	718,807	3,249,052	(546,508)	2,702,544	9,787	2,712,331			16
	C. General Administration											
17	Administrative	83,008			83,008		83,008	70,264	153,272			17
18	Directors Fees											18
19	Professional Services			259,679	259,679		259,679	(245,333)	14,346			19
20	Dues, Fees, Subscriptions & Promotions			61,780	61,780	(45,443)	16,337	3,984	20,321			20
21	Clerical & General Office Expenses	199,535	25,989	12,153	237,677		237,677	143,830	381,507			21
22	Employee Benefits & Payroll Taxes			500,972	500,972		500,972	26,392	527,364			22
23	Inservice Training & Education			4,099	4,099		4,099	(2,100)	1,999			23
24	Travel and Seminar			1,106	1,106		1,106	893	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			54,174	54,174		54,174	9,441	63,615			26
27	Other (specify):*			13,930	13,930		13,930	(12,000)	1,930			27
28	TOTAL General Administration	282,543	25,989	907,893	1,216,425	(45,443)	1,170,982	(4,629)	1,166,353			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,712,662	1,055,347	1,817,162	5,585,171	(591,951)	4,993,220	18,963	5,012,183			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 Manor #0042168 Report Period Beginning: 1-01-10 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			129,713	129,713		129,713	7,895	137,608			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			181,449	181,449		181,449	(3,495)	177,954			32
33	Real Estate Taxes			111,204	111,204		111,204	46	111,250			33
34	Rent-Facility & Grounds			8,629	8,629		8,629	4,548	13,177			34
35	Rent-Equipment & Vehicles			7,857	7,857		7,857	1,008	8,865			35
36	Other (specify):*											36
37	**TOTAL Ownership**			438,852	438,852		438,852	10,002	448,854			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					546,508	546,508		546,508			39
40	Barber and Beauty Shops			6,580	6,580		6,580		6,580			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					45,443	45,443		45,443			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			6,580	6,580	591,951	598,531		598,531			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,712,662	1,055,347	2,262,594	6,030,603		6,030,603	28,965	6,059,568			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 Manor # 0042168 Report Period Beginning: 1-01-10 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space	(950)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(3,996)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)	(2,409)	23		16
17	Non-Care Related Fees	(396)	20		17
18	Fines and Penalties				18
19	Entertainment	(5,736)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,790)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(4,128)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (32,405)		$	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)	61,370		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 61,370		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 28,965		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

Colonial Manor

ID# 0042168

Report Period Beginning: 1-01-10

Ending: 12-31-10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(396)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(2,790)	19	22
23				23
24		(12,000)	27	24
25		(4,128)	20	25
26				26
27				27
28				28
29		0	33	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**	(19,314)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Colonial Manor **#** 0042168 **Report Period Beginning:** 1-01-10 **Ending:** 12-31-10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,308	0	0	0	0	0	0	0	0	3,308	1
2	Food Purchase	0	0	(781)	0	0	0	0	0	0	0	0	(781)	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	1,429	0	0	0	0	0	0	0	0	1,429	5
6	Maintenance	0	0	9,849	0	0	0	0	0	0	0	0	9,849	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	13,805	0	0	0	0	0	0	0	0	13,805	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,430	0	0	0	0	0	0	0	0	2,430	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	6,257	0	0	0	0	0	0	0	0	0	6,257	10a
11	Activities	0	0	3	0	0	0	0	0	0	0	0	3	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,097	0	0	0	0	0	0	0	0	1,097	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	6,257	3,530	0	0	0	0	0	0	0	0	9,787	16
	C. General Administration													
17	Administrative	0	0	70,264	0	0	0	0	0	0	0	0	70,264	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,790)	(256,889)	14,346	0	0	0	0	0	0	0	0	(245,333)	19
20	Fees, Subscriptions & Promotions	(4,524)	0	8,508	0	0	0	0	0	0	0	0	3,984	20
21	Clerical & General Office Expenses	0	0	143,830	0	0	0	0	0	0	0	0	143,830	21
22	Employee Benefits & Payroll Taxes	0	0	26,392	0	0	0	0	0	0	0	0	26,392	22
23	Inservice Training & Education	(2,409)	0	309	0	0	0	0	0	0	0	0	(2,100)	23
24	Travel and Seminar	(5,736)	0	6,629	0	0	0	0	0	0	0	0	893	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	9,441	0	0	0	0	0	0	0	0	9,441	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	**TOTAL General Administration**	(27,459)	(256,889)	279,719	0	0	0	0	0	0	0	0	(4,629)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,459)	(250,632)	297,054	0	0	0	0	0	0	0	0	18,963	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Colonial Manor # 0042168 **Report Period Beginning:** 1-01-10 **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	0	0	0	7,895	0	0	0	0	0	0	0	7,895	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,996)	0	0	501	0	0	0	0	0	0	0	(3,495)	32
33	Real Estate Taxes	0	0	0	46	0	0	0	0	0	0	0	46	33
34	Rent-Facility & Grounds	(950)	0	0	5,498	0	0	0	0	0	0	0	4,548	34
35	Rent-Equipment & Vehicles	0	0	0	1,008	0	0	0	0	0	0	0	1,008	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,946)	0	0	14,948	0	0	0	0	0	0	0	10,002	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)**	(32,405)	(250,632)	297,054	14,948	0	0	0	0	0	0	0	28,965	45

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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
Heritage Enterprises, Inc.	100	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			$			$	$	1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	6,257	6,257	2
3	V								3
4	V	19	Adjustment for Related Organization	256,889	Heritage Operations Group, LLC	0.00%		(256,889)	4
5	V								5
6	V	34	Adjustment for Related Organization		Heritage Manor Real Estate, LLC	0.00%			6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				10
11	V								11
12	V								12
13	V								13
14	Total			$ 256,889			$ 6,257	$ * (250,632)	14

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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. ☐ 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	1	Dietary	$	Heritage Enterprises, Inc.		$	$ 3,308	15
16	V	2	Food Purchase					(781)	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,429	19
20	V	6	Maintenance					9,849	20
21	V	7	Other					0	21
22	V	9	Medical Director					2,430	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					3	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,097	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					70,264	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					14,346	31
32	V	20	Fees, Subscription, Promotions					8,508	32
33	V	21	Clerical & General Office Expenses					143,830	33
34	V	22	Employee Benefits & Payroll Taxes					26,392	34
35	V	23	Inservice Training & Education					309	35
36	V	24	Travel and Seminar					6,629	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					9,441	38
39	Total			$			$ 0	$ * 297,054	39

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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. ☐ 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	27	Other	$	Heritage Enterprises, Inc.		$	$ 0	15
16	V	30	Depreciation					7,895	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					501	18
19	V	33	Real Estate Taxes					46	19
20	V	34	Rent-Facility & Grounds					5,498	20
21	V	35	Rent-Equipment & Vehicles					1,008	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 14,948	39

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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 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	Heritage Enterprises Inc.	Member		100.00					$ 0	18/7	1
2											2
3											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 Manor # 0042168 Report Period Beginning: 1-01-10 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: Heritage Operations Group
Street Address: box 3188
City / State / Zip Code: Bloomington, Il 61701
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,634	25	$ 104,969	$ 104,969	83	$ 3,308	1
2	2	Food Purchase	Beds	2,634	25	(24,794)	0	83	(781)	2
3	3	Housekeeping	Beds	2,634	25	0	0	83	0	3
4	4	Laundry	Beds	2,634	25	0	0	83	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	45,364	0	83	1,429	5
6	6	Maintenance	Beds	2,634	25	312,555	75,007	83	9,849	6
7	7	Other	Beds	2,634	25	0	0	83	0	7
8	9	Medical Director	Beds	2,634	25	77,111	0	83	2,430	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	77,111	83	0	9
10	11	Activities	Beds	2,634	25	95	0	83	3	10
11	12	Social Service	Beds	2,634	25	0	0	83	0	11
12	13	Nurse Aide Training	Beds	2,634	25	34,804	0	83	1,097	12
13	14	Program Transportation	Beds	2,634	25	0	0	83	0	13
14	15	Other	Beds	2,634	25	0	0	83	0	14
15	17	Administrative	Beds	2,634	25	2,229,831	2,229,831	83	70,264	15
16	18	Directors Fees	Beds	2,634	25	0	0	83	0	16
17	19	Professional Services	Beds	2,634	25	455,276	0	83	14,346	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	269,994	0	83	8,508	18
19	21	Clerical & General Office Expens	Beds	2,634	25	4,564,447	4,163,572	83	143,830	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	837,533	0	83	26,392	20
21	23	Inservice Training & Education	Beds	2,634	25	9,793	0	83	309	21
22	24	Travel and Seminar	Beds	2,634	25	210,373	0	83	6,629	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	83	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	299,608	0	83	9,441	24
25	TOTALS					$ 9,426,959	$ 6,650,490		$ 297,054	25

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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 ☐ NO ☐

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

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

	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	27	Other	Beds	2,634	25	$	$	83	$	1
2	30	Depreciation	Beds	2,634	25	250,538		83	7,895	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25			83		3
4	32	Interest	Beds	2,634	25	15,900		83	501	4
5	33	Real Estate Taxes	Beds	2,634	25	1,448		83	46	5
6	34	Rent-Facility & Grounds	Beds	2,634	25	174,472		83	5,498	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	31,994		83	1,008	7
8	36	Other	Beds	2,634	25			83		8
9	38	Medically Nec Transportation	Beds	2,634	25			83		9
10	39	Ancillary Service Centers	Beds	2,634	25			83		10
11	40	Barber and Beauty Shops	Beds	2,634	25			83		11
12	41	Coffee and Gift Shops	Beds	2,634	25			83		12
13	42	Other	Beds	2,634	25			83		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 474,352	$		$ 14,948	25

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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	Busey Bank		xx	Mortgage			$	$ 2,679,729	3/2011	variable	$ 171,814	1
2	Busey Bank		xx	Loan Fees							3,597	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							6,038	6
7												7
8												8
9	TOTAL Facility Related						$	$ 2,679,729			$ 181,449	9
	B. Non-Facility Related*											
10	Interest Income										(3,996)	10
11	Allocated Corporate										501	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,495)	14
15	TOTALS (line 9+line14)						$	$ 2,679,729			$ 177,954	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

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

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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.**	$ 113,196	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.)		$ 109,463	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,733)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 114,937	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.		$ 111,204	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	93,692	8
	2006	107,707	9
	2007	107,826	10
	2008	112,075	11
	2009	111,204	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 Manor COUNTY Vermillion

FACILITY IDPH LICENSE NUMBER 0042168

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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.	23071020190030	nursing home	$ 207.00	$ 207.00
2.	23071020150060		$ 82,798.00	$ 82,798.00
3.	23071020250060		$ 26,458.00	$ 26,458.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 109,463.00	$ 109,463.00

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 Manor # 0042168 Report Period Beginning: 1-01-10 Ending: 12-31-10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,996 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

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

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

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

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

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

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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				$ 111,000	1
2					2
3	TOTALS			$ 111,000	3

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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	83				$ 1,709,475	$		$	$	$	4
5					33,000						5
6											6
7											7
8											8
	Improvement Type**										
9	Architect Fees			1997	46,312						9
10	Property @ 607 Cunningham			1997	50,000						10
11											11
12	Architect Fees			1998	15,039						12
13	Door Replacement			1998	6,993						13
14	Water Pump			1998	1,439						14
15	Generator Gaskets			1998	1,011						15
16	Hallway Door			1998	800						16
17	Canapy			1998	1,526						17
18	Dumpster Pad			1998	4,100						18
19	Iron Fence			1998	900						19
20	Floor Drain			1998	800						20
21	Railing			1998	900						21
22	Addition--Materials			1998	762,036						22
23	Addition--Labor			1998	48						23
24	Addition--Professional Fees			1998	7,546						24
25	Washer/Dryer Repair			1998	1,619						25
26	Addition--Materials			1999	181,865						26
27	Addition--Professional Fees			1999	3,782						27
28	WAN Building Materials			1999	4,698						28
29	Roof Repair			1999	1,783						29
30											30
31											31
32											32
33	C/O Allocation							7,895	7,895		33
34	Book Depreciation					96,369		96,369			34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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	Window Replacements	2000	$ 3,005	$		$	$	$	37
38	Water Heater	2000	3,798						38
39									39
40	Nurse Call System	2001	24,949						40
41	Coax Cable	2001	945						41
42	Roof Sheathing	2001	1,314						42
43									43
44	Door Alarm	2002	2,383						44
45	Roof	2002	38,165						45
46	Water Heater	2002	3,656						46
47	Heater/Air Conditioning Unit	2002	1,843						47
48	Fire Dampers	2002	523						48
49	A/C Unit	2002	566						49
50	Security Door	2002	1,127						50
51	Dishwasher Motor	2002	1,129						51
52	Sealcoat Parking Lot	2002	1,955						52
53									53
54	Blackflow Prevention	2003	672						54
55	Repair/Replace Doors	2003	7,866						55
56	A/C Unit	2003	495						56
57	Fire Supression System	2003	1,286						57
58									58
59	Automatic Transfer Switch	2004	3,458						59
60	Aero Air Condensor	2004	1,508						60
61	Parking Lot Sealant	2004	2,379						61
62									62
63	Kitchen Air Handler	2005	2,855						63
64	Condensor	2005	2,086						64
65	A/C Unit	2005	995						65
66	Ramp and Rails	2005	808						66
67	A/C Condensor	2005	2,313						67
68	Concrete	2005	1,714						68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,949,465	$ 96,369		$ 104,264	$ 7,895	$	70

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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	
1	Totals from Page 12A, Carried Forward		$ 2,949,465	$ 96,369		$ 104,264	$ 7,895	$	1
2	Sprinkler	2006	11,094						2
3	Condensor	2006	2,324						3
4	A/C unit	2006	754						4
5	Roof	2006	1,900						5
6	Parking Lot	2006	2,379						6
7	Backflow preventer	2006	1,400						7
8	Sprinkler	2006	2,693						8
9	A/C unit	2006	1,161						9
10	Dry pendant	2006	1,010						10
11									11
12	Exhaust Fans	2007	674						12
13	Hot Water Liner	2007	700						13
14	HVAC	2007	9,599						14
15	Heat Coil	2007	2,776						15
16	HVAC condensor	2007	4,625						16
17	Fire Door	2007	600						17
18	Sprinkler system	2007	4,945						18
19	Front Pourch	2007	3,932						19
20	Room Repair	2007	980						20
21	Boiler	2007	5,257						21
22	Carpet	2007	615						22
23									23
24	Carpeting	2008	20,682						24
25	Basement Stairs	2008	2,694						25
26	Metal Doors	2008	2,510						26
27	A/C unit	2008	7,891						27
28	Air Handling Unit	2008	3,237						28
29	Fire System	2008	2,525						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,048,422	$ 96,369		$ 104,264	$ 7,895	$	34

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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	
1	Totals from Page 12B, Carried Forward		$ 3,048,422	$ 96,369		$ 104,264	$ 7,895	$	1
2	Emergency Backflow	2009	2,572						2
3	Gutters	2009	8,250						3
4	Awning	2009	4,070						4
5	Aurora Pump	2009	2,969						5
6	HVAC	2009	2,729						6
7	Doors	2009	7,368						7
8	Asphalt	2009	29,982						8
9	Windows	2009	4,050						9
10									10
11	HVAC	2010	2,816						11
12	Roof	2010	91,520						12
13	Windows	2010	4,050						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	TOTAL (lines 1 thru 33)		$ 3,208,798	$ 96,369		$ 104,264	$ 7,895	$	34

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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	
1	Totals from Page 12C, Carried Forward		$ 3,208,798	$ 96,369		$ 104,264	$ 7,895	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,208,798	$ 96,369		$ 104,264	$ 7,895	$	34

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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	$ 402,826	$ 33,344	$ 33,344	$		$	71
72	Current Year Purchases	72,276						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 475,102	$ 33,344	$ 33,344	$		$	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)	$	3,794,900	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	129,713	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	137,608	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	7,895	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$		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 Manor # 0042168 Report Period Beginning: 1-01-10 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: $ 7,857 Description:
(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 Manor # 0042168 Report Period Beginning: 1-01-10 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 ☐ 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 Manor # 0042168 Report Period Beginning: 1-01-10 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	$		$ 309,846	$		$ 309,846	1
2	Licensed Speech and Language Development Therapist		hrs			9,898			9,898	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			314,839	7,226		322,065	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				482,278		482,278	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					64,230			64,230	13
14	TOTAL			$		$ 698,813	$ 489,504		$ 1,188,317	14

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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	$ 58,349	$	1
2	Cash-Patient Deposits	3,271		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	508,766		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,072		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,436,162		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,025,620	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	112,000		13
14	Buildings, at Historical Cost	3,255,252		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	475,102		16
17	Accumulated Depreciation (book methods)	(1,443,994)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,398,360	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,423,980	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 277,505	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,271		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	225,301		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,259		31
32	Accrued Real Estate Taxes(Sch.IX-B)	114,937		32
33	Accrued Interest Payable	14,307		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 664,580	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,679,729		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)**	$ 2,679,729	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,344,309	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,079,671	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,423,980	$	48

***(See instructions.)**

Facility Name & ID Number Colonial Manor **#** 0042168 **Report Period Beginning:** 1-01-10 **Ending:** 12-31-10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 797,027	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 797,027	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	282,644	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 282,644	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,079,671	24 *

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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	$ 6,079,169	1
2	Discounts and Allowances for all Levels	(2,963,984)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,115,185	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,440,660	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,440,660	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	50	12
13	Barber and Beauty Care	6,205	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	950	16
17	Sale of Drugs	734,933	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,268	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 753,406	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,996	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,996	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,313,247	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,119,694	31
32	Health Care	3,249,052	32
33	General Administration	1,216,425	33
	B. Capital Expense		
34	Ownership	438,852	34
	C. Ancillary Expense		
35	Special Cost Centers	6,580	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,030,603	40
41	**Income before Income Taxes (line 30 minus line 40)****	282,644	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 282,644	43

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

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

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

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

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 Ending: 12-31-10

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,048	2,160	$ 80,889	$ 37.45	1
2	Assistant Director of Nursing	1,808	2,160	56,819	26.31	2
3	Registered Nurses	14,163	15,583	363,859	23.35	3
4	Licensed Practical Nurses	25,026	26,818	494,189	18.43	4
5	CNAs & Orderlies	65,331	70,737	749,922	10.60	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	6,968	7,628	72,447	9.50	10
11	Social Service Workers	1,516	1,584	47,377	29.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,822	24,708	264,803	10.72	15
16	Dishwashers					16
17	Maintenance Workers	5,980	6,531	98,846	15.13	17
18	Housekeepers	10,901	9,689	129,872	13.40	18
19	Laundry	9,569	10,231	71,096	6.95	19
20	Administrator	1,900	2,080	83,008	39.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,108	9,033	199,535	22.09	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)	176,140	188,942	$ 2,712,662 *	$ 14.36	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		$ 0		35
36	Medical Director		8,400		36
37	Medical Records Consultant		1,680		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,980		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,866		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,926		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 Ending: 12-31-10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark black			$ 83,008
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,008

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
Heritage Operations Group	Mgt Fee	$ 256,889
McQuellen Consulting	R/E appeals	0
Legal adj to Zero		2,790
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 259,679

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,893
Unemployment Compensation Insurance	23,843
FICA Taxes	207,519
Employee Health Insurance	190,628
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	0
Other Benefits	23,089
Central Office Allocation	26,392
TOTAL (agree to Schedule V, line 22, col.8)	$ 527,364

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	1,559
Health Care Worker Background Check	
(Indicate # of checks performed)	3,052
Patient Background Checks	
	2,356
Dues & Subscriptions	5,436
License & Fees	2,162
Central Office Allocation	8,508
Less: Public Relations Expense	(2,356)
Non-allowable advertising	(396)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,321

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
	0
Seminar Expense	1,106
Central Office	893
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 1-01-10 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		$		$	$	$	$	$	$	$	$	$

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. **Illinois Health Care Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **x** NO 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. $ **45,443**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **3,812**

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **sulaski & webb**

(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.