		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 42168

Facility Name: Colonial Manor

Address: 620 Warrington (Number) Danville (City) (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	[x]	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: 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 01/01/11 to 12/31/11 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 Ater
(Title) Exec VP & 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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

	1 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	9,014	12,485	4,742	26,241	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,014	12,485	4,742	26,241	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.62%

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 [x] Date 1996 NO [ ]

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 4,742

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] 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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	245,259	5,803		251,062		251,062	4,657	255,719			1
2	Food Purchase		203,602		203,602		203,602	16	203,618			2
3	Housekeeping	125,451	34,602		160,053		160,053	7	160,060			3
4	Laundry	82,323	13,894		96,217		96,217	5	96,222			4
5	Heat and Other Utilities			114,076	114,076		114,076	1,640	115,716			5
6	Maintenance	104,942	133,922	75,607	314,471		314,471	12,071	326,542			6
7	Other (specify):*											7
8	TOTAL General Services	557,975	391,823	189,683	1,139,481		1,139,481	18,396	1,157,877			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400	67	8,467			9
10	Nursing and Medical Records	1,694,572	131,274	9,153	1,834,999		1,834,999		1,834,999			10
10a	Therapy		480,093	603,458	1,083,551	(523,390)	560,161	(18,198)	541,963			10a
11	Activities	70,697	4,954		75,651		75,651		75,651			11
12	Social Services	47,969		3,866	51,835		51,835		51,835			12
13	CNA Training							668	668			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,813,238	616,321	624,877	3,054,436	(523,390)	2,531,046	(17,463)	2,513,583			16
	C. General Administration											
17	Administrative	80,415			80,415		80,415	70,862	151,277			17
18	Directors Fees											18
19	Professional Services			270,971	270,971		270,971	(262,501)	8,470			19
20	Dues, Fees, Subscriptions & Promotions			63,581	63,581	(45,443)	18,138	889	19,027			20
21	Clerical & General Office Expenses	201,896	18,597	13,360	233,853		233,853	156,349	390,202			21
22	Employee Benefits & Payroll Taxes			573,082	573,082		573,082	32,875	605,957			22
23	Inservice Training & Education			2,093	2,093		2,093	(94)	1,999			23
24	Travel and Seminar			2,571	2,571		2,571	(572)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,101	55,101		55,101	9,634	64,735			26
27	Other (specify):*			13,620	13,620		13,620	(12,000)	1,620			27
28	TOTAL General Administration	282,311	18,597	994,379	1,295,287	(45,443)	1,249,844	(4,558)	1,245,286			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,653,524	1,026,741	1,808,939	5,489,204	(568,833)	4,920,371	(3,625)	4,916,746			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 #42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			160,404	160,404		160,404	9,780	170,184			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			176,148	176,148		176,148	(743)	175,405			32
33	Real Estate Taxes			109,206	109,206		109,206		109,206			33
34	Rent-Facility & Grounds			7,692	7,692		7,692	(7,781)	(89)			34
35	Rent-Equipment & Vehicles			7,599	7,599		7,599	773	8,372			35
36	Other (specify):*											36
37	**TOTAL Ownership**			461,049	461,049		461,049	2,029	463,078			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					523,390	523,390		523,390			39
40	Barber and Beauty Shops			5,530	5,530		5,530		5,530			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**			5,530	5,530	568,833	574,363		574,363			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,653,524	1,026,741	2,275,518	5,955,783		5,955,783	(1,596)	5,954,187			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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(880)	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	(1,244)	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)	(502)	23		16
17	Non-Care Related Fees	(398)	20		17
18	Fines and Penalties				18
19	Entertainment	(8,448)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,958)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(3,303)	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)**	$ (37,733)		$	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)	36,137		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 36,137		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,596)		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# 42168

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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		(398)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(10,958)	19	22
23				23
24		(12,000)	27	24
25		(3,303)	20	25
26				26
27				27
28				28
29			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**	(26,659)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Colonial Manor # 42168 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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	4,657	0	0	0	0	0	0	0	0	4,657	1
2	Food Purchase	0	0	16	0	0	0	0	0	0	0	0	16	2
3	Housekeeping	0	0	7	0	0	0	0	0	0	0	0	7	3
4	Laundry	0	0	5	0	0	0	0	0	0	0	0	5	4
5	Heat and Other Utilities	0	0	1,640	0	0	0	0	0	0	0	0	1,640	5
6	Maintenance	0	0	12,071	0	0	0	0	0	0	0	0	12,071	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	18,396	0	0	0	0	0	0	0	0	18,396	8
	B. Health Care and Programs													
9	Medical Director	0	0	67	0	0	0	0	0	0	0	0	67	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(18,198)	0	0	0	0	0	0	0	0	0	(18,198)	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	668	0	0	0	0	0	0	0	0	668	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	(18,198)	735	0	0	0	0	0	0	0	0	(17,463)	16
	C. General Administration													
17	Administrative	0	0	70,862	0	0	0	0	0	0	0	0	70,862	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,958)	(260,013)	8,470	0	0	0	0	0	0	0	0	(262,501)	19
20	Fees, Subscriptions & Promotions	(3,701)	0	4,590	0	0	0	0	0	0	0	0	889	20
21	Clerical & General Office Expenses	0	0	156,349	0	0	0	0	0	0	0	0	156,349	21
22	Employee Benefits & Payroll Taxes	0	0	32,875	0	0	0	0	0	0	0	0	32,875	22
23	Inservice Training & Education	(502)	0	408	0	0	0	0	0	0	0	0	(94)	23
24	Travel and Seminar	(8,448)	0	7,876	0	0	0	0	0	0	0	0	(572)	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	9,634	0	0	0	0	0	0	0	0	9,634	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	**TOTAL General Administration**	(35,609)	(260,013)	291,064	0	0	0	0	0	0	0	0	(4,558)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,609)	(278,211)	310,195	0	0	0	0	0	0	0	0	(3,625)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Colonial Manor # 42168 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	9,780	0	0	0	0	0	0	0	9,780	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,244)	0	0	501	0	0	0	0	0	0	0	(743)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(880)	(7,692)	0	791	0	0	0	0	0	0	0	(7,781)	34
35	Rent-Equipment & Vehicles	0	0	0	773	0	0	0	0	0	0	0	773	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,124)	(7,692)	0	11,845	0	0	0	0	0	0	0	2,029	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)**	(37,733)	(285,903)	310,195	11,845	0	0	0	0	0	0	0	(1,596)	45

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100	See Page 25				

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)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(18,198)	(18,198)	2
3	V								3
4	V	19	Adjustment for Related Organization	260,013	Heritage Operations Group, LLC	0.00%		(260,013)	4
5	V								5
6	V	34	Adjustment for Related Organization	7,692	Heritage Manor Real Estate, LLC	0.00%		(7,692)	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			$ 267,705			$ (18,198)	$ * (285,903)	14

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

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.		$	$ 4,657	15
16	V	2	Food Purchase					16	16
17	V	3	Housekeeping					7	17
18	V	4	Laundry					5	18
19	V	5	Heat & Other Utilities					1,640	19
20	V	6	Maintenance					12,071	20
21	V	7	Other					0	21
22	V	9	Medical Director					67	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					668	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					70,862	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					8,470	31
32	V	20	Fees, Subscription, Promotions					4,590	32
33	V	21	Clerical & General Office Expenses					156,349	33
34	V	22	Employee Benefits & Payroll Taxes					32,875	34
35	V	23	Inservice Training & Education					408	35
36	V	24	Travel and Seminar					7,876	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					9,634	38
39	Total			$			$ 0	$ * 310,195	39

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

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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					9,780	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					501	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					791	20
21	V	35	Rent-Equipment & Vehicles					773	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	$ * 11,845	39

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

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1	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	Heritage Enterprises Inc.	Member		100.00					$ 0		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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2,735	26	$ 153,442	$ 153,115	83	$ 4,657	1
2	2	Food Purchase	Beds	2,735	26	520	0	83	16	2
3	3	Housekeeping	Beds	2,735	26	215	0	83	7	3
4	4	Laundry	Beds	2,735	26	151	0	83	5	4
5	5	Heat & Other Utilities	Beds	2,735	26	54,054	0	83	1,640	5
6	6	Maintenance	Beds	2,735	26	397,756	75,127	83	12,071	6
7	7	Other	Beds	2,735	26	0	0	83	0	7
8	9	Medical Director	Beds	2,735	26	2,206	0	83	67	8
9	10	Nursing & Medical Records	Beds	2,735	26	0	0	83	0	9
10	11	Activities	Beds	2,735	26	0	0	83	0	10
11	12	Social Service	Beds	2,735	26	0	0	83	0	11
12	13	Nurse Aide Training	Beds	2,735	26	22,009	20,793	83	668	12
13	14	Program Transportation	Beds	2,735	26	0	0	83	0	13
14	15	Other	Beds	2,735	26	0	0	83	0	14
15	17	Administrative	Beds	2,735	26	2,335,023	2,335,023	83	70,862	15
16	18	Directors Fees	Beds	2,735	26	0	0	83	0	16
17	19	Professional Services	Beds	2,735	26	279,109	0	83	8,470	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	151,258	0	83	4,590	18
19	21	Clerical & General Office Expens	Beds	2,735	26	5,151,979	4,517,846	83	156,349	19
20	22	Employee Benefits & Payroll Tax	Beds	2,735	26	1,083,278	0	83	32,875	20
21	23	Inservice Training & Education	Beds	2,735	26	13,460	0	83	408	21
22	24	Travel and Seminar	Beds	2,735	26	259,533	0	83	7,876	22
23	25	Other Admin. Staff Transportatio	Beds	2,735	26	0	0	83	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	317,454	0	83	9,634	24
25	TOTALS					$ 10,221,447	$ 7,101,904		$ 310,195	25

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	27	Other	Beds	2,735	26	$	$	83	$	1
2	30	Depreciation	Beds	2,735	26	322,258		83	9,780	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			83		3
4	32	Interest	Beds	2,735	26	16,517		83	501	4
5	33	Real Estate Taxes	Beds	2,735	26			83		5
6	34	Rent-Facility & Grounds	Beds	2,735	26	26,080		83	791	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	25,461		83	773	7
8	36	Other	Beds	2,735	26			83		8
9	38	Medically Nec Transportation	Beds	2,735	26			83		9
10	39	Ancillary Service Centers	Beds	2,735	26			83		10
11	40	Barber and Beauty Shops	Beds	2,735	26			83		11
12	41	Coffee and Gift Shops	Beds	2,735	26			83		12
13	42	Other	Beds	2,735	26			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					$ 390,316	$		$ 11,845	25

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Busey Bank		xx	Mortgage			$	$	03/2016	variable	$ 164,468	1
2	Busey Bank		xx	Loan Fees							8,083	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							3,597	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 176,148	9
	B. Non-Facility Related*											
10	Interest Income										(1,244)	10
11	Allocated Corporate										501	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (743)	14
15	TOTALS (line 9+line14)						$	$			$ 175,405	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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 114,937	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.)		$ 109,338	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,599)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 114,805	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.		$ 109,206	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	93,692	8
	2007	107,707	9
	2008	107,826	10
	2009	112,075	11
	2010	109,206	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Colonial Manor COUNTY Vermillion

FACILITY IDPH LICENSE NUMBER 42168

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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23071020150060	nursing home	$ 81,259.00	$ 81,259.00
2.	23071020250060		$ 25,967.00	$ 25,967.00
3.	23071020190030		$ 203.00	$ 203.00
4.	23071020130060		$ 1,909.00	$ 1,909.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 109,338.00	$ 109,338.00

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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											10
11											11
12	Architect Fees			1998							12
13	Door Replacement			1998							13
14	Water Pump			1998							14
15	Generator Gaskets			1998							15
16	Hallway Door			1998							16
17	Canapy			1998							17
18	Dumpster Pad			1998							18
19	Iron Fence			1998							19
20	Floor Drain			1998	768,055						20
21	Railing			1998							21
22	Addition--Materials			1998							22
23	Addition--Labor			1998							23
24	Addition--Professional Fees			1998							24
25	Washer/Dryer Repair			1998							25
26	Addition--Materials			1999	146,931						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							9,780	9,780		33
34	Book Depreciation					120,823		120,823			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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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							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)		$ 2,826,700	$ 120,823		$ 130,603	$ 9,780	$	70

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

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 2,826,700	$ 120,823		$ 130,603	$ 9,780	$	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									12
13									13
14	HVAC	2007	9,599						14
15	Heat Coil	2007	2,776						15
16	HVAC condensor	2007	4,625						16
17									17
18	Sprinkler system	2007	4,945						18
19	Front Pourch	2007	3,932						19
20	Room Repair	2007							20
21	Boiler	2007	5,257						21
22									22
23									23
24	Carpeting	2008	20,547						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)		$ 2,921,953	$ 120,823		$ 130,603	$ 9,780	$	34

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

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 2,921,953	$ 120,823		$ 130,603	$ 9,780	$	1
2									2
3	Emergency Backflow	2009	2,572						3
4	Gutters	2009	8,250						4
5	Awning	2009	4,070						5
6	Aurora Pump	2009	2,969						6
7	HVAC	2009	2,729						7
8	Doors	2009	7,368						8
9	Asphalt	2009	29,063						9
10	Windows	2009	4,050						10
11									11
12	HVAC	2010	2,816						12
13	Roof	2010	91,520						13
14	Windows	2010	4,050						14
15	fire control panel	2010	3,609						15
16									16
17									17
18	Nurse Call & Tech System	2011	304,131						18
19	Office space/storage & lot	2011	41,838						19
20	Roof	2011	3,977						20
21	Concrete	2011	5,090						21
22	Windows * installation	2011	30,060						22
23	Steel door	2011	8,595						23
24	sign	2011	9,067						24
25	Building repair	2011	2,938						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,490,715	$ 120,823		$ 130,603	$ 9,780	$	34

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

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 475,102	$ 39,581	$ 39,581	$		$	71
72	Current Year Purchases	39,935						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 515,037	$ 39,581	$ 39,581	$		$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,116,752	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 160,404	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 170,184	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,780	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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 7,599 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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 271,582	$		$ 271,582	1
2	Licensed Speech and Language Development Therapist		hrs			8,639			8,639	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			275,724	4,216		279,940	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				475,877		475,877	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					47,513			47,513	13
14	TOTAL			$		$ 603,458	$ 480,093		$ 1,083,551	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 **#** 42168 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/11 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 56,408	$	1
2	Cash-Patient Deposits	2,461		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	728,057		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,257		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	800,174		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,609,357	$	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	3,673,956		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	515,037		16
17	Accumulated Depreciation (book methods)	(1,604,398)		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):	14,089		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,710,684	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,320,041	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 228,922	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,461		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	225,078		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,887		31
32	Accrued Real Estate Taxes(Sch.IX-B)	114,805		32
33	Accrued Interest Payable	13,682		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)**	$ 589,835	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,562,798		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)**	$ 2,562,798	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,152,633	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,167,408	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,320,041	$	48

***(See instructions.)**

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 879,672	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 879,672	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	287,736	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)**	$ 287,736	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)**	$ 1,167,408	24	*

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

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,908,858	1
2	Discounts and Allowances for all Levels	(2,649,616)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,259,242	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,145,465	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,145,465	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	154	12
13	Barber and Beauty Care	4,510	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	880	16
17	Sale of Drugs	838,704	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(6,680)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 837,568	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,244	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,244	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			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)**	$ 6,243,519	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,139,481	31
32	Health Care	3,054,436	32
33	General Administration	1,295,287	33
	B. Capital Expense		
34	Ownership	461,049	34
	C. Ancillary Expense		
35	Special Cost Centers	5,530	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)***	$ 5,955,783	40
41	**Income before Income Taxes (line 30 minus line 40)****	287,736	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 287,736	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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,032	$ 88,227	$ 43.42	1
2	Assistant Director of Nursing	1,968	2,056	63,641	30.95	2
3	Registered Nurses	12,519	12,872	322,004	25.02	3
4	Licensed Practical Nurses	21,643	22,852	491,330	21.50	4
5	CNAs & Orderlies	61,819	65,117	729,370	11.20	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	6,084	6,262	70,697	11.29	10
11	Social Service Workers	2,633	2,788	47,969	17.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,971	21,816	245,259	11.24	15
16	Dishwashers					16
17	Maintenance Workers	6,983	7,331	104,942	14.31	17
18	Housekeepers	12,127	12,433	125,451	10.09	18
19	Laundry	8,172	8,561	82,323	9.62	19
20	Administrator	1,900	2,080	80,415	38.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,359	9,844	201,896	20.51	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)	168,138	176,044	$ 2,653,524 *	$ 15.07	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		$ 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 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark black			$ 80,415
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,415

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	$ 260,013
		0
		0
Legal adj to Zero		10,958
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 270,971

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,545
Unemployment Compensation Insurance	29,747
FICA Taxes	202,995
Employee Health Insurance	250,891
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	0
Other Benefits	18,904
Central Office Allocation	32,875
TOTAL (agree to Schedule V, line 22, col.8)	$ 605,957

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	1,271
Health Care Worker Background Check	
(Indicate # of checks performed)	2,986
Patient Background Checks	
	1,169
Dues & Subscriptions	5,426
License & Fees	5,152
Central Office Allocation	4,590
Less: Public Relations Expense	(1,169)
Non-allowable advertising	(398)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,027

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,179
	67
Seminar Expense	325
Central Office	(572)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Manor # 42168 Report Period Beginning: 01/01/11 Ending: 12/31/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **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? **7 years**

(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 **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **xx** 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. $ **4,529**

(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

Related Parties
From Page 6

FACILITY
Owned SNFs
Heritage Health - South, LLC
Heritage Health - Bloomington, LLC
Heritage Health - Carlinville, LLC
Heritage Health - Chillicothe, LLC
Heritage Health - Dwight, LLC
Heritage Health - Elgin, LLC
Heritage Health - El Paso, LLC
Heritage Health - Gibson City, LLC
Heritage Health - Gillespie, LLC
Heritage Health - LaSalle, LLC
Heritage Health - Litchfield, LLC
Heritage Health - Mendota, LLC
Heritage Health - Minonk, LLC
Heritage Health - Mt. Sterling, LLC
Heritage Health - Mt. Zion, LLC
Heritage Health - Normal, LLC
Heritage Health - Pana, LLC
Heritage Health - Peru, LLC
Heritage Health - Staunton, LLC
Heritage Health - Streator, LLC
Barton W. Stone Jacksonville, LLC
Danville Joint Ventures, LLC d/b/aColonial Manor
Heritage Health - Springfield
Cotillion Ridge
Country Health
Mason City Area NH
St. Clara's Manor
Vonderlieth Living Center