		FOR BHF USE					

LL1

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

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0053413

Facility Name: COLONIAL MANOR

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

County: Vermillion

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

HFS ID Number:

Date of Initial License for Current Owners: 2015

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: David M Underwood **Telephone Number:** 309823-7135
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 1/1/2018 to 12/31/2018 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) David M Underwood
(Title) EVP/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 # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	90	Skilled (SNF)	90	32,850	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	90	TOTALS	90	32,850	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	10,800	9,610	5,326	25,736	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,800	9,610	5,326	25,736	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.34%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 2015

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 90 and days of care provided 5,326

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 # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	277,232	20,055	8,489	305,776		305,776	3,632	309,408			1
2	Food Purchase		189,946		189,946		189,946	48	189,994			2
3	Housekeeping	117,095	42,784		159,879		159,879		159,879			3
4	Laundry	69,070	16,259		85,329		85,329	4	85,333			4
5	Heat and Other Utilities			96,890	96,890		96,890	1,319	98,209			5
6	Maintenance	95,235	61,202	70,547	226,984		226,984	19,936	246,920			6
7	Other (specify):*											7
8	**TOTAL General Services**	558,632	330,246	175,926	1,064,804		1,064,804	24,939	1,089,743			8
	B. Health Care and Programs											
9	Medical Director			18,750	18,750		18,750		18,750			9
10	Nursing and Medical Records	2,156,474	168,385	11,280	2,336,139		2,336,139	(23,087)	2,313,052			10
10a	Therapy		569,640	61,499	631,139	(629,759)	1,380		1,380			10a
11	Activities	67,562	429		67,991		67,991		67,991			11
12	Social Services	46,313		4,417	50,730		50,730		50,730			12
13	CNA Training							1,044	1,044			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,270,349	738,454	95,946	3,104,749	(629,759)	2,474,990	(22,043)	2,452,947			16
	C. General Administration											
17	Administrative	99,950			99,950		99,950		99,950			17
18	Directors Fees											18
19	Professional Services			348,316	348,316		348,316	(331,234)	17,082			19
20	Dues, Fees, Subscriptions & Promotions			216,682	216,682	(169,795)	46,887	(19,545)	27,342			20
21	Clerical & General Office Expenses	265,413	27,113	21,628	314,154		314,154	319,107	633,261			21
22	Employee Benefits & Payroll Taxes			483,729	483,729		483,729	41,622	525,351			22
23	Inservice Training & Education			4,472	4,472		4,472	527	4,999			23
24	Travel and Seminar			5,224	5,224		5,224	(225)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,480	36,480		36,480	22,446	58,926			26
27	Other (specify):* **Lost resident items**			40,162	40,162		40,162	(39,862)	300			27
28	**TOTAL General Administration**	365,363	27,113	1,156,693	1,549,169	(169,795)	1,379,374	(7,164)	1,372,210			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,194,344	1,095,813	1,428,565	5,718,722	(799,554)	4,919,168	(4,268)	4,914,900			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 #0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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							359,049	359,049			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,284	48,284		48,284	213,101	261,385			32
33	Real Estate Taxes							97,648	97,648			33
34	Rent-Facility & Grounds			373,632	373,632		373,632	(368,421)	5,211			34
35	Rent-Equipment & Vehicles			34,588	34,588		34,588	5,590	40,178			35
36	Other (specify):*											36
37	**TOTAL Ownership**			456,504	456,504		456,504	306,967	763,471			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			854,361	854,361	629,759	1,484,120	(59,180)	1,424,940			39
40	Barber and Beauty Shops			2,318	2,318		2,318		2,318			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					169,795	169,795		169,795			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			856,679	856,679	799,554	1,656,233	(59,180)	1,597,053			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,194,344	1,095,813	2,741,748	7,031,905		7,031,905	243,519	7,275,424			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 # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(310)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,370)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(820)			17
18	Fines and Penalties				18
19	Entertainment	(6,920)			19
20	Contributions	(25)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,172)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,837)			24
25	Fund Raising, Advertising and Promotional	(28,236)			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)**	$ (80,690)		$	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)	324,209		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 324,209		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 243,519		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# 0053413

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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		(310)	34	22
23		(1,172)	19	23
24		(39,837)	27	24
25		(28,236)	20	25
26		(6,920)	24	26
27		(25)	27	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(76,500)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	3,632	0	0	0	0	0	0	0	0	3,632	1
2	Food Purchase	0	0	48	0	0	0	0	0	0	0	0	48	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	4	0	0	0	0	0	0	0	0	4	4
5	Heat and Other Utilities	0	0	1,319	0	0	0	0	0	0	0	0	1,319	5
6	Maintenance	0	0	19,936	0	0	0	0	0	0	0	0	19,936	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	24,939	0	0	0	0	0	0	0	0	24,939	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(23,668)	581	0	0	0	0	0	0	0	0	(23,087)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,044	0	0	0	0	0	0	0	0	1,044	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	(23,668)	1,625	0	0	0	0	0	0	0	0	(22,043)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,172)	(345,462)	15,400	0	0	0	0	0	0	0	0	(331,234)	19
20	Fees, Subscriptions & Promotions	(28,236)	0	8,691	0	0	0	0	0	0	0	0	(19,545)	20
21	Clerical & General Office Expenses	0	0	319,107	0	0	0	0	0	0	0	0	319,107	21
22	Employee Benefits & Payroll Taxes	0	0	41,622	0	0	0	0	0	0	0	0	41,622	22
23	Inservice Training & Education	(820)	(216)	1,563	0	0	0	0	0	0	0	0	527	23
24	Travel and Seminar	(6,920)	0	6,695	0	0	0	0	0	0	0	0	(225)	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	22,446	0	0	0	0	0	0	0	0	22,446	26
27	Other (specify):*	(39,862)	0	0	0	0	0	0	0	0	0	0	(39,862)	27
28	**TOTAL General Administration**	(77,010)	(345,678)	415,524	0	0	0	0	0	0	0	0	(7,164)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(77,010)	(369,346)	442,088	0	0	0	0	0	0	0	0	(4,268)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	333,646	0	25,403	0	0	0	0	0	0	0	359,049	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,370)	216,471	0	0	0	0	0	0	0	0	0	213,101	32
33	Real Estate Taxes	0	97,648	0	0	0	0	0	0	0	0	0	97,648	33
34	Rent-Facility & Grounds	(310)	(373,632)	0	5,521	0	0	0	0	0	0	0	(368,421)	34
35	Rent-Equipment & Vehicles	0	0	0	5,590	0	0	0	0	0	0	0	5,590	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,680)	274,133	0	36,514	0	0	0	0	0	0	0	306,967	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	(59,180)	0	0	0	0	0	0	0	0	0	(59,180)	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	(59,180)	0	0	0	0	0	0	0	0	0	(59,180)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(80,690)	(154,393)	442,088	36,514	0	0	0	0	0	0	0	243,519	45

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy

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	10	Adjustment for Related Organizat	$	GreenTree Pharmacy		$ (23,668)	$ (23,668)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(216)	(216)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		(59,180)	(59,180)	3
4	V	19	Adjustment for Related Organization	345,462	Heritage Operations Group, LLC			(345,462)	4
5	V								5
6	V	34	Adjustment for Related Organization	373,632	Heritage Manor Real Estate, LLC			(373,632)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		97,648	97,648	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		216,471	216,471	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		333,646	333,646	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			$ 719,094			$ 564,701	$ * (154,393)	14

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

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Operations Group		$	$ 3,632	15
16	V	2	Food Purchase		Heritage Operations Group			48	16
17	V	3	Housekeeping		Heritage Operations Group			0	17
18	V	4	Laundry		Heritage Operations Group			4	18
19	V	5	Heat & Other Utilities		Heritage Operations Group			1,319	19
20	V	6	Maintenance		Heritage Operations Group			19,936	20
21	V	7	Other		Heritage Operations Group			0	21
22	V	9	Medical Director		Heritage Operations Group			0	22
23	V	10	Nursing & Medical Records		Heritage Operations Group			581	23
24	V	11	Activities		Heritage Operations Group			0	24
25	V	12	Social Service		Heritage Operations Group			0	25
26	V	13	Nurse Aide Training		Heritage Operations Group			1,044	26
27	V	14	Program Transportation		Heritage Operations Group			0	27
28	V	15	Other		Heritage Operations Group			0	28
29	V	17	Administrative		Heritage Operations Group			0	29
30	V	18	Directors Fees		Heritage Operations Group			0	30
31	V	19	Professional Services		Heritage Operations Group			15,400	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group			8,691	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group			319,107	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group			41,622	34
35	V	23	Inservice Training & Education		Heritage Operations Group			1,563	35
36	V	24	Travel and Seminar		Heritage Operations Group			6,695	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group			0	37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group			22,446	38
39	Total			$			$ 0	$ * 442,088	39

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

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Operations Group		$	$ 0	15
16	V	30	Depreciation		Heritage Operations Group			25,403	16
17	V	31	Amortization of Pre-Op & Org		Heritage Operations Group			0	17
18	V	32	Interest		Heritage Operations Group			0	18
19	V	33	Real Estate Taxes		Heritage Operations Group			0	19
20	V	34	Rent-Facility & Grounds		Heritage Operations Group			5,521	20
21	V	35	Rent-Equipment & Vehicles		Heritage Operations Group			5,590	21
22	V	36	Other		Heritage Operations Group			0	22
23	V	38	Medically Nec Transportation		Heritage Operations Group			0	23
24	V	39	Ancillary Service Centers		Heritage Operations Group			0	24
25	V	40	Barber and Beauty Shops		Heritage Operations Group			0	25
26	V	41	Coffee and Gift Shops		Heritage Operations Group			0	26
27	V	42	Other		Heritage Operations Group			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	$ * 36,514	39

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

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.			100.00					$		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 # 0053413 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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	2,578	26	$ 104,045	$ 103,180	90	$ 3,632	1
2	2	Food Purchase	Beds	2,578	26	1,362	0	90	48	2
3	3	Housekeeping	Beds	2,578	26	0	0	90	0	3
4	4	Laundry	Beds	2,578	26	111	0	90	4	4
5	5	Heat & Other Utilities	Beds	2,578	26	37,778	0	90	1,319	5
6	6	Maintenance	Beds	2,578	26	571,069	80,581	90	19,936	6
7	7	Other	Beds	2,578	26	0	0	90	0	7
8	9	Medical Director	Beds	2,578	26	0	0	90	0	8
9	10	Nursing & Medical Records	Beds	2,578	26	16,650	12,036	90	581	9
10	11	Activities	Beds	2,578	26	0	0	90	0	10
11	12	Social Service	Beds	2,578	26	0	0	90	0	11
12	13	Nurse Aide Training	Beds	2,578	26	29,896	28,423	90	1,044	12
13	14	Program Transportation	Beds	2,578	26	0	0	90	0	13
14	15	Other	Beds	2,578	26	0	0	90	0	14
15	17	Administrative	Beds	2,578	26	0	0	90	0	15
16	18	Directors Fees	Beds	2,578	26	0	0	90	0	16
17	19	Professional Services	Beds	2,578	26	441,112	0	90	15,400	17
18	20	Fees, Subscription, Promotions	Beds	2,578	26	248,958	0	90	8,691	18
19	21	Clerical & General Office Expense	Beds	2,578	26	9,140,644	8,773,931	90	319,107	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,578	26	1,192,239	0	90	41,622	20
21	23	Inservice Training & Education	Beds	2,578	26	44,777	0	90	1,563	21
22	24	Travel and Seminar	Beds	2,578	26	191,781	0	90	6,695	22
23	25	Other Admin. Staff Transportation	Beds	2,578	26	0	0	90	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,578	26	642,946	0	90	22,446	24
25	TOTALS					$ 12,663,368	$ 8,998,151		$ 442,088	25

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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	2,578	26	$	$	90	$	1
2	30	Depreciation	Beds	2,578	26	727,658		90	25,403	2
3	31	Amortization of Pre-Op & Org	Beds	2,578	26			90		3
4	32	Interest	Beds	2,578	26			90		4
5	33	Real Estate Taxes	Beds	2,578	26			90		5
6	34	Rent-Facility & Grounds	Beds	2,578	26	158,134		90	5,521	6
7	35	Rent-Equipment & Vehicles	Beds	2,578	26	160,109		90	5,590	7
8	36	Other	Beds	2,578	26			90		8
9	38	Medically Nec Transportation	Beds	2,578	26			90		9
10	39	Ancillary Service Centers	Beds	2,578	26			90		10
11	40	Barber and Beauty Shops	Beds	2,578	26			90		11
12	41	Coffee and Gift Shops	Beds	2,578	26			90		12
13	42	Other	Beds	2,578	26			90		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					$ 1,045,901	$		$ 36,514	25

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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		x	Mortgage			$	$			$ 216,471	1
2	Busey Bank		x	Loan Fee Amortization								2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		x	Working Capital							48,284	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 264,755	9
	B. Non-Facility Related*											
10	Interest Income										(3,370)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,370)	14
15	TOTALS (line 9+line14)						$	$			$ 261,385	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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 # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$ 97,648	2
3. Under or (over) accrual (line 2 minus line 1).		$ 97,648	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$ 97,648	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	84,989	8
	2014	85,295	9
	2015	90,222	10
	2016	94,460	11
	2017	97,648	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COLONIAL MANOR COUNTY Vermillion

FACILITY IDPH LICENSE NUMBER 0053413

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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	2307102013		$ 516.50	$ 517.00
2.	2307108005		$ 1,216.24	$ 1,216.00
3.	2307102019		$ 209.48	$ 209.00
4.	2307102025		$ 19,281.94	$ 19,282.00
5.	2307108001		$ 1,782.50	$ 1,783.00
6.	2301102015		$ 74,641.44	$ 74,641.00
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 97,648.10	$ 97,648.00

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 x NO

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,770 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

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				$ 112,000	1
2					2
3	TOTALS			$ 112,000	3

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	90				$ 1,709,475	$		$	$	$	4
5					33,000						5
6											6
7											7
8											8
	Improvement Type**										
9	1997 Improvements			1997	46,312						9
10	1998 Improvements			1998	768,055						10
11	1999 Improvements			1999	157,194						11
12	2000 Improvements			2000	6,803						12
13	2001 Improvements			2001	27,208						13
14	2002 Improvements			2002	50,218						14
15	2003 Improvements			2003	10,319						15
16	2004 Improvements			2004	7,345						16
17	2005 Improvements			2005	10,771						17
18	2006 Improvements			2006	24,715						18
19	2007 Improvements			2007	31,134						19
20	2008 Improvements			2008	39,404						20
21	2009 Improvements			2009	61,071						21
22	2010 Improvements			2010	101,995						22
23	2011 Improvements			2011	405,696						23
24	2012 Improvements			2012	2,667						24
25											25
26	2013 - No Improvements			2013							26
27											27
28	Replace Fire Sprinkler			2014	3,317						28
29	Replace (10) PTAC Units			2014	4,759						29
30	Parking Lot Fill, Seal and Striping			2014	5,373						30
31	Cabling and Electrical - Point of Care Kiosks			2014	11,904						31
32	Architect Planning Fees - 2015 Remodeling Project			2014	8,454						32
33											33
34	C/O Allocation					25,403		25,403			34
35	Book Depreciation					250,254		250,254			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 # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			$	$		$	$	$	37
38	Installation of split AC system - dining room	2015	22,128						38
39									39
40	No 2016 Improvements	2016							40
41									41
42	Install (3) Islandaire 12 K 230 V cooling units	2017	4,137						42
43									43
44	Install new hot water line - Laundry	2018	9,875						44
45	Install new awning covers	2018	7,520						45
46	Replace dry valve - fire sprinkler system	2018	5,827						46
47	Replace door holders - fire alarm system	2018	2,665						47
48									48
49	Completed Addition and Renovation -	2018	4,686,477						49
50	Addition - Attached seven new rooms and a therapy gym								50
51	to the west side of the existing facility.								51
52	Renovation -								52
53	Every existing resident room received new paint, fixtures,								53
54	flooring, wallcovers (where applicable) and cabinets								54
55	All nursing stations were rebuilt with new desks and								55
56	enhanced IT infrastructure capability								56
57	Relocated laundry from basement to ground level								57
58	Installed new canopies over the main entrance								58
59	Developed existing unused land into additional parking								59
60	Installed new sprinkler system								60
61	Re-landscaped exterior								61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,265,818	$ 275,657		$ 275,657	$	$	70

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

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 578,648	$ 77,544	$ 77,544	$		$	71
72	Current Year Purchases	550,719						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,129,367	$ 77,544	$ 77,544	$		$	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		2016 Dodge Grand Caravan	2016	$ 40,938	$ 5,848	$ 5,848	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 40,938	$ 5,848	$ 5,848	$		$	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)	$ 9,548,123	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 359,049	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 359,049	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	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 # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 34,588 Description: Televisons and office equipment
(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 # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Facility Drop-outs	2 Facility Completed	3 Contract	4 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.

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	$		$ 440,390	$		$ 440,390	1
2	Licensed Speech and Language Development Therapist		hrs			81,495			81,495	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			332,476	1,380		333,856	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				568,260		568,260	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					61,499			61,499	13
14	TOTAL			$		$ 915,860	$ 569,640		$ 1,485,500	14

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

STATE OF ILLINOIS

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 692	$	1
2	Cash-Patient Deposits	4,280		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,116,736		3
4	Supply Inventory (priced at FIFO)	16,631		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,420		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(855,547)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 285,212	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 285,212	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 123,116	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,280		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	319,293		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,735		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	10,131		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 464,555	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 464,555	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (179,343)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 285,212	$	48

*(See instructions.)

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (220,407)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (220,407)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	41,064	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)**	$ 41,064	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)**	$ (179,343)	24 *

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

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,922,620	1
2	Discounts and Allowances for all Levels	(4,105,435)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,817,185	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,135,558	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,135,558	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,460	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	310	16
17	Sale of Drugs	1,111,651	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,015	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,116,436	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,370	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,370	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund income	420	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 420	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,072,969	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,064,804	31
32	Health Care	3,104,749	32
33	General Administration	1,549,169	33
	B. Capital Expense		
34	Ownership	456,504	34
	C. Ancillary Expense		
35	Special Cost Centers	856,679	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)***	$ 7,031,905	40
41	**Income before Income Taxes (line 30 minus line 40)****	41,064	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 41,064	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

* **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 # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	1,740	1,852	$ 73,377	$ 39.62	1
2	Assistant Director of Nursing	1,842	1,960	58,266	29.73	2
3	Registered Nurses	21,084	22,430	726,431	32.39	3
4	Licensed Practical Nurses	13,230	14,074	389,663	27.69	4
5	CNAs & Orderlies	57,002	60,640	865,675	14.28	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,938	2,062	43,062	20.88	8
9	Activity Director					9
10	Activity Assistants	4,709	5,009	67,562	13.49	10
11	Social Service Workers	1,733	1,844	46,313	25.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,527	21,838	277,232	12.69	15
16	Dishwashers					16
17	Maintenance Workers	5,248	5,583	95,235	17.06	17
18	Housekeepers	10,426	11,092	117,095	10.56	18
19	Laundry	6,085	6,473	69,070	10.67	19
20	Administrator	1,955	2,080	99,950	48.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,106	10,751	265,413	24.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,625	167,688	$ 3,194,344 *	$ 19.05	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		$ 8,489		35
36	Medical Director		18,750		36
37	Medical Records Consultant		1,754		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,653		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		4,417		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 38,063		49

C. CONTRACT NURSES

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

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marsha Lock			$ 99,950
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,950

B. Administrative - Other

Description	Amount
	$ 0
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	Management	$ 347,144
Legal adj to Zero		1,172
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 348,316

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,254
Unemployment Compensation Insurance	17,066
FICA Taxes	244,367
Employee Health Insurance	175,368
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	18,674
Central Office Allocation	41,622
TOTAL (agree to Schedule V, line 22, col.8)	$ 525,351

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	$
Advertising: Employee Recruitment	6,316
Health Care Worker Background Check	
(Indicate # of checks performed)	5,256
Patient Background Checks	
PR	3,303
Dues & Subscriptions	4,568
License & Fees	4,764
Central Office Allocation	8,691
Less: Public Relations Expense	(3,303)
Non-allowable advertising	(2,253)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,342

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,313
	56
Seminar Expense	855
	(225)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number COLONIAL MANOR # 0053413 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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. **Health Care Council of Illinois**

(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 Yrs**

(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 NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **169,795**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,700**

(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. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **May Cocagne & King**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **None Claimed**
Attach invoices and a summary of services for all architect and appraisal fees

Account Number		Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 Line #	pg 5 Adjustment Amount	
1009		PETTY CASH	692						
1010		CASH IN BANK							
1040		CASH IN BANK-PAYROLL							
1100		ACCOUNTS RECEIVABLE	1,116,736						
1110		MEDICARE RECEIVABLES							
1125		IPA INCOME RECEIVABLE							
1130		MEDICARE COST REPORT							
1135		ACCOUNTS RECEIVABLE-IC							
1140		UNAPPLIED CASH RECEIPTS							
1145		A/R SUSPENSE-REFUNDS							
1190		ACCRUED INTEREST REC							
1200		PREPAID INSURANCE	2,420						
1220		OTHER PREPAID EXPENSES							
1300		FOOD INVENTORY	16,631						
1310		SUPPLIES INVENTORY							
1409		LAND	0						
1450		FURNITURE & EQUIPMENT	0						
1460		ACCUM DEPR-FURN & EQUIP	0						
1475		BUILDING & IMPROVEMENTS	0						
1490		ACCUM DEPR-BUILDING	0						
1530		RESIDENT FUNDS	4,280						
1550		LOAN FEES	0						
1560		REAL ESTATE TAX ESCROW							
1575		REIMBURSABLE PURCHASES							
1850		INTRACOMPANY	-855,547						
2010		ACCOUNTS PAYABLE	-123,116						
2095		BONUSES PAYABLE							
2100		ACCRUED PAYROLL	-149,579						
2110		ACCRUED VACATION PAY	-169,714						
2120		UC TAXES PAYABLE							
2125		FICA TAX PAYABLE	-7,735	-7,735					
2130		FIT PAYABLE							
2140		STATE W/H PAYABLE		0					
2145		EARNED INCOME CREDIT							
2150		UC FED CREDIT REDUCTION							
2230		PAYROLL SAVINGS							
2235		IRA W/HOLDINGS							
2240		UNITED WAY							
2245		GROUP INSURANCE PAYABLE							
2246		GROUP INSURANCE PAYABLE-CAFETERIA							
2260		WAGE GARNISHMENTS							
2280		MISC PAYROLL DEDUCTIONS							
2300		ACCRUED INTEREST PAYABLE	0						
2310		SALES TAX PAYABLE							
2320		IPA PAYMENTS PAYABLE	-10,131						
2350		REAL ESTATE TAX PAYABLE	0						
2385		ACTIVITY FUND	0						
2390		SECURITY DEPOSITS	0						
2391		VOLUNTEER FUND							
2393		HEART FUND/BAZAAR							
2395		DEFERRED INC EMP & MEM							
2400		CURRENT PORTION LT DEBT							
2460		INCOME TAXES PAYABLE							
2512		DUE TO RESIDENTS	-4,280						
2600		MORTGAGE PAYABLE	0						
2650		EQUIPMENT LOAN PAYABLE							
2695		CURRENT PORTION LT DEBT							
2696		DEFERRED INCOME TAXES							
2710		COMMON STOCK							
2720		RETAINED EARNINGS	220,407						
2970		PROFIT/LOSS FOR PERIOD	-41,064						
3007.1		PATIENT DAYS-PRIVATE	9,610						
3007.2		PATIENT DAYS-IPA	10,800						
3007.3		PATIENT DAYS-MEDICARE	5,326						
3007.4		PATIENT DAYS-CONVERSION							
3007.5		PATIENT DAYS-LICENSED							
3007.6		PATIENT DAYS-TOTAL							
3010		1 BASIC CHARGE-PRIVATE & VA	-6,882,069		0	0	0	0	
3015		1 PRIVATE ASSESSMENT TAX INCOME			0	0	0	0	
3020		1 BASIC CHARGE-IPA	0		0	0	0	0	
3030		1 BASIC CHARGE-MEDICARE	0		0	0	0	0	
3035		4 DAY CARE/HOME CARE			0	0	0	0	
3040		1 LIGHT NURSING CARE	0		0	0	0	0	
3050		1 MEDIUM NURSING CARE			0	0	0	0	
3060		1 HEAVY NURSING CARE			0	0	0	0	
3061		1 SKILLED NURSING CARE							
3080		1 NURSING SUPPLIES-PRIVATE	-34,229		0	0	0	0	
3081		1 NURSING SUPPLIES-IPA			0	0	0	0	
3082		1 NURSING SUPPLIES MED PT A			0	0	0	0	
3083		1 NURSING SUPPLIES MED PT B							
3100		17 DRUGS	-1,111,651		0	0	0	0	
3101		17 DRUGS-OTHER							
3110		6 PT-PRIVATE	-3,135,558		0	0	0	0	
3111		6 PT-IPA			0	0	0	0	
3112		6 PT-MEDICARE PART A			0	0	0	0	
3113		6 PT-MEDICARE PART B			0	0	0	0	
3130		1 PUBLIC AID ASSESSMENT INC	120,520						
3140		19 LABORATORY INCOME			0	0	0	0	
3150		6 SPEECH/OT-PRIVATE			0	0	0	0	
3151		6 SPEECH/OT-IPA			0	0	0	0	
3152		6 SPEECH/OT-MED PART A			0	0	0	0	
3153		6 SPEECH/OT MED PART B							
3410		2 IPA DISCOUNTS	4,105,435		0	0	0	0	
3411		2 MEDICAID PART B DISCOUNT			0	0	0	0	
3420		2 MEDICARE DISCOUNTS			0	0	0	0	
3440		36 ASSESSMENT TAX EXPENSE			42	3	0	0	
3520		16 RENT INCOME	-310		6	0	6	-310	
3530		13 BEAUTY SHOP	-2,460		0	0	0	0	
3560		12 ACTIVITY FUND INCOME	-420		0	0	0	0	
3570		12 VENDING INCOME/EXPENSE	-800		0	0	0	0	
3580		12 MANAGEMENT FEES			0	0	0	0	
3590		1 EQUIPMENT RENTAL	-6,322		0	0	0	0	
3595		21 RESIDENT TRANSPORTATION	-1,150		0	0	0	0	
3600		21 MISC INCOME	-65		0	0	0	0	
4110		GENERAL & ADMINIST WAGES	240,119	265,413	21	1	17	0	
4111		ADMINISTRATOR WAGES	99,950	99,950	17	1	0	0	
4115		VACATION & SICK - G&A	25,294		21	1	0	0	
4120	4475	EMPLOYEE BENEFITS	18,674	483,729	22	3	0	0	
4125		EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130		EMPLOYEE SCHOLARSHIP WA(	0	120,520	21	1	0	0	
4135		EMPLOYEE SCHOLARSHIP CO!	0		23	3	0	0	
4220		DIRECTORS FEES	0	0	18	3	0	0	
4250	4255	OFFICE SUPPLIES	27,113	27,113	21	2	0	0	
4260		TELEPHONE	21,628	21,628	21	3	0	0	
4275		TRAINING & EMPLOYEE DEVL	4,472	4,472	23	3	16	-820	**
4280		GENERAL TRAVEL	4,313	5,224	24	3	16	0	
4281		MEAL EXPENSE FOR TRAVEL	56		24	3	19	0	
4285		EDUCATION & SEMINAR	855		24	3	19	-6,920	***
4290		HELP WANTED ADVERTISING	6,316	96,162	20	3	0	0	-49,275
4291		PROMOTIONAL ADVERTISING	22,680		20	3	25	-22,680	
4292		PUBLIC RELATIONS	3,303		20	3	25	-3,303	
4300		LICENSES & FEES	54,039		20	3	17	0	
4310		DUES & SUBSCRIPTIONS	4,568		20	3	17	-2,253	
4320		CONTRIBUTIONS	25		27	3	20	-25	
4350		PROFESSIONAL FEES	2,854	348,316	19	3	22	-1,172	
4355		MEDICAL DIRECTOR	18,750	18,750	9	3	0	0	
4360		UTILIZATION REVIEW	0		10	3	0	0	
4361		OTHER PHYSICIAN FEES			39	3	0	0	
4362		MEDICAL RECORDS CONSULT	1,754		10	3	0	0	
4363		PHARMACIST FEES	4,653		10	3	0	0	
4364		SOC SERV/ACT CONSULT	4,417	4,417	12	3	0	0	
4370		TV RENTAL	19,450		35	3	5	0	
4380		INCOME TAXES		40,162	27	3	26	0	
4383		BACKGROUND CHECKS	5,256		20	3	26	0	
4400		PAYROLL TAXES	261,433		22	3	0	0	
4401		PAYROLL TAXES ADMINIST	0		22	3	0	0	
4410		GROUP INSURANCE	175,368		22	3	0	0	
4420		LIABILITY INSURANCE	36,480	36,480	26	3	0	0	
4425		INSURANCE-OWNERS			22	3	21	0	
4430		WORKMENS COMP INSURANCE	28,254		22	3	0	0	
4450		CENTRAL OFFICE FEES	345,462		19	3	34	0	**
4460		BAD DEBTS	39,837		27	3	24	-39,837	
4470		LOST ITEMS-RESIDENTS	300		27	3	0		
4490		MISCELLANEOUS	0		27	3	0	0	
4510		REAL ESTATE TAXES	0	0	33	3	0	0	
4600		LEASED EQUIPMENT	15,138	34,588	35	3	16	0	
5110		MAINTENANCE SALARIES	89,653	95,235	6	1	0	0	
5120		MAINTENANCE SICK & VAC	5,582		6	1	0	0	
5130		ELECTRIC	47,055	96,890	5	3	0	0	
5131		NATURAL GAS	20,972		5	3	0	0	
5132		HEATING & DEISEL OIL			5	3	0	0	
5133		WATER & SEWER	28,863		5	3	0	0	
5134		TRASH COLLECTION	10,597	70,547	6	3	0	0	
5140		PROPERTY PLANT REPLACEMI	16,054	61,202	6	2	0	0	
5160		GENERAL REPAIR & MAINT	45,148		6	2	0	0	
5165		MAINTENANCE CONTRACTS	59,950		6	3	0	0	
5210		DIETARY WAGES	254,828	277,232	1	1	0	0	
5220		DIETARY SICK & VAC	22,404		1	1	0	0	
5240		DIETARY CONSULT	8,489	8,489	2	3	13	0	
5248		FOOD PURCHASES	191,646	189,946	2	2	0	0	
5250		SUPPLIES-DISHWASHING	8,287	20,055	1	2	0	0	
5260		DIETARY REPLACEMENT	1,805		1	2	0	0	
5270		KITCHEN SUPPLIES-PAPER	9,963		1	2	0	0	
5295		MEAL CREDIT	-1,700		2	2	0	0	
5310		LAUNDRY WAGES	65,618	69,070	4	1	0	0	
5340		LAUNDRY SICK & VAC	3,452		4	1	0	0	
5370		LAUNDRY REPLACEMENT	9,325	16,259	4	2	0	0	
5380		LAUNDRY REIMBURSEMENT			4	3	0	0	
5390		LAUNDRY SUPPLIES	6,934		4	2	0	0	
5410		HOUSEKEEPING WAGES	107,662	117,095	3	1	0	0	
5440		HOUSEKEEPING SICK & VAC	9,433		3	1	0	0	
5480		HOUSEKEEPING SUPPLIES	42,784	42,784	3	2	0	0	
5490		HOUSEKEEPING SUPPLIES-PPR	0		3	2	0	0	
6010		RN WAGES-MEDICARE		2,156,474	10	1	0	0	
6020		RN WAGES-NON MEDICARE	682,337		10	1	0	0	
6030		DON WAGES	73,377		10	1	0	0	
6035		ADON	58,266		10	1	0	0	
6040		RN SICK & VACATION	44,094		10	1	0	0	
6110		LPN WAGES-MEDICARE	354,596		10	1	0	0	
6120		LPN WAGES-NON MEDICARE	0		10	1	0	0	
6130		LPN WAGES OTHER			10	1	0	0	
6140		LPN SICK & VACATION	35,067		10	1	0	0	
6210		AIDE WAGES-MEDICARE			10	1	0	0	
6220		AIDE WAGES-NON MEDICARE	820,239		10	1	0	0	
6230		WARD CLERKS			10	1	0	0	
6240		AIDE VACATION & SICK	45,436		10	1	0	0	
6245		CONTRACT NURSES-RN	0		10	3	0	0	
6246		CONTRACT NURSES-LPN	0		10	3	0	0	
6247		CONTRACT NURSES-AIDES	0		10	3	0	0	
6250		NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	
6255		NURSE AID TRAINING EXP	0	0	13	2	0	0	
6260		NURSE AIDE TRAINING REIMB	0		0	0	0	0	
6270		REHAB WAGES	40,041		10	1	0	0	
6275		REHAB SICK & VAC	3,021		10	1	0	0	
6280		NURSING DEPT EDUCATION			23	3	0	0	
6290		NURSING SUPPLIES	40,600	168,385	10	2	0	0	
6295		NURSING SUPPLIES	122,353		10	2	0	0	
6390		REPLACEMENT-NURSING	5,432		10	2	0	0	
6490		NURSING OTHER	4,873	11,280	10	3	0	0	
7280		DRUG PURCHASES	568,260	569,640	39	2	0	0	***
7281		DRUG PURCHASES-OTHER	0		39	2			
7380		LABORATORY SERVICES	61,499	61,499	39	3	0	0	
7410		HOME HEALTH SALARY			39	1	0	0	
7440		HOME HEALTH SICK & VAC			39	1	0	0	
7450		HOME HEALTH EXPENSES			39	3	0	0	
7510		ACTIVITES WAGES	63,669	67,562	11	1	0	0	
7540		ACTIVITIES SICK & VAC	3,893		11	1	0	0	
7590		ACTIVITIES SUPPLIES	429	429	11	2	0	0	
7595		ACTIVITIES FEES	0	0	11	3	0	0	
7610		PT WAGES			39	1	0	0	
7611		PT SICK & VACATION			39	1	0	0	
7620		PT FEES	332,476	854,361	39	3	0	0	***
7660		PT SUPPLIES	1,380		39	2	0	0	
7710		SOCIAL SERVICE WAGES	41,914	46,313	12	1	0	0	
7720		SOCIAL SERVICE SICK & VAC	4,399		12	1	0	0	
7730		SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	
7740		OT FEE	440,390		39	3	0	0	***
7750		SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770		SPEECH THERAPY FEE	81,495		39	3	0	0	***
7800		BEAUTICIAN WAGES		0	40	1	0	0	
7810		BEAUTICIAN SICK & VAC			40	1	0	0	
7820		BEAUTICIAN FEES	2,318	2,318	40	3	0	0	
7890		BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910		VOLUNTEER COORDINATOR			21	1	0	0	
7940		VOL COORD SICK & VAC			21	1	0	0	
7960		VOL COORD SUPPLIES	0		21	2	0	0	
8100		RENT	373,632	373,632	34	3	0	0	
8120		INTEREST EXPENSE	48,284	48,284	32	3	14	-3,370	
8130		DEPRECIATION	0	0	30	3	9	0	
8150		LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510		INTEREST INCOME	-3,370		32	0	10	0	
9520		MISC NON-OPERATING INCOME	0		0	0	0	0	
9700		INCOME TAXES	0		0	0	0	0	
			6,908,015	7,031,905					
				123,890					
GRAND TOTALS			-41,064					-80,690	
			(NET INCOME)						
			0						

1,009	1,009	CASH	692
1,100	1,100	ACCTS RECEI	1,296,072
1,101	1,101	ALLOW. FOR U	(179,336)
1,110	1,110	ACCTS RECEIV-M/C	
1,125	1,125	ACCTS RECEIV-IPA	
1,135	1,135	ACCTS RECEIV-IC	
1,140	1,140	UNAPPLIED CASH RECEIPTS	
1,145	1,145	A/R SUSPENSE-REFUNDS	
1,200	1,200	PREPAID INSU	2,420
1,220	1,220	OTHER PREPAID EXPENSES	
1,300	1,300	DIETARY INVE	16,631
1,310	1,310	SUPPLIES INVENTORY	
1,320	1,320	LINEN INVENTORY	
1,409	1,409	LAND	0
1,450	1,450	FURNITURE &	0
1,460			0
1,475	1,475	BUILDINGS	0
1,490	1,490	ACCUM DEPR	0
1,530	1,530	RESIDENT FU	4,280
1,550	1,550	LOAN FEES	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCOMPA	(855,547)
2,010	2,010	ACCOUNTS PA	(123,116)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUED PA	(149,579)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUED PTO	(169,714)
2,120	2,120	U.C. TAXES PA	0
2,125	2,125	FICA TAXES P	(7,735)
2,130	2,130	FEDERAL W/H TAX PAYABLE	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE REFUND	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETERIA	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GARNIS	
2,300	2,300	ACCRUED INT	0
2,320	2,320	IPA PAYMENT	(10,131)
2,350	2,350	REAL ESTATE	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO RESID	(4,280)
2,600	2,600	LASALLE BAN	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DEBT	
2,720	2,720	RETAINED EA	220,407
		net income	(41,064)
		balance	0

3,007	3,007	PATIENT DAYS-PI	9,610
3,007	3,007	PATIENT DAYS-IP	10,800
3,007	3,007	PATIENT DAYS-M	5,326
3,007			0
3,007			
3,007			
3,007			
3,010	3,010	BASIC CHARGE-P	(6,882,069)
3,020	3,020	BASIC CHARGE-II	0
3,030	3,030	BASIC CHARGE-M	0
3,040		ASSESSMENT	120,520
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING SUPPL-	(34,229)
3,081	3,081	NURSING SUPPLI	0
3,082	3,082	NURSING SUPPLI	0
3,083	3,083	NURSING SUPPLI	0
3,100	3,100	DRUGS-MEDICAR	(1,111,651)
3,101			0
3,110	3,110	PHYSICAL THERA	(3,135,558)
3,111			0
3,112	3,112	PHYSICAL THERA	0
3,113	3,113	PHYSICAL THERA	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT THERAPY-I	0
3,153	3,153	ST/OT THERAPY-I	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHER DISC(	0
3,411	3,411	MEDICARE PT B-I	0
3,420	3,420	MEDICARE DISC(	4,078,732
3,500			
3,520	3,520	RENT INCOME	(310)
3,530	3,530	BEAUTY SHOP	(2,460)
3,560			(420)
3,570	3,570	VENDING INCOME	(800)
3,590	3,590	EQUIPMENT REN'	(6,322)
3,595	3,595	RESIDENT TRANS	(1,150)
3,600	3,600	MISC INCOME	(65)
4,110	4,110	G&A WAGES	240,119
4,111	4,111	ADMINISTRATOR	99,950
4,115	4,115	G&A PTO & RESE	25,294
4,120	4,120	EMPLOYEE BENE	15,381
4,121			0
4,130	4,130	EMPLOYEE SCHC	0
4,135	4,135	EMPLOYEE SCHC	0
4,250	4,250	OFFICE SUPPLIES	9,816
4,255	4,255	POSTAGE	1,411
4,260	4,260	TELEPHONE	21,628
4,275	4,275	TRAINING & EMPL	4,472
4,276			348
4,280	4,280	GENERAL TRAVE	4,313
4,281	4,281	MEAL EXPENSE F	56
4,285	4,285	EDUCATION/SEMI	855
4,289	4,289	MEETINGS EXPEI	0
4,290	4,290	HELP WANTED AI	6,316
4,291	4,291	PROMOTIONAL AI	22,680
4,292	4,292	PUBLIC RELATIOI	3,303
4,300	4,300	LICENSE & FEES	54,039
4,310	4,310	DUES & SUBSCRI	4,568
4,320	4,320	CONTRIBUTIONS	25
4,350	4,350	PROFESSIONAL F	2,854
4,355	4,355	MEDICAL DIRECT	18,750
4,362			1,754
4,363			4,653
4,364	4,364	SOCIAL SERV/AC'	4,417
4,370	4,370	TV RENTAL	19,450
4,383	4,383	BACKGROUND CI	5,256
4,390	4,390	OTHER TAXES	0
4,400	4,400	PAYROLL TAXES	261,433
4,401	4,401	PAYROLL TAXES	0
4,410	4,410	GROUP INSURAN	175,368
4,420	4,420	LIABILITY INSURA	36,480
4,430	4,430	WORKMAN'S COI	25,534
4,435	4,435	W/C-FIRST AID CL	0
4,436	4,436	DRUG TESTING M	2,372
4,450	4,450	MANAGEMENT FE	345,462
4,460	4,460	BAD DEBTS	39,837
4,461	4,461	BAD DEBTS	26,703
4,470	4,470	LOST ITEMS-RESI	300
4,475	4,475	UNIFORM EXP/PE	3,293
4,486	4,486	MIS -MAINT	42,524
4,490	4,490	MISC EXPENSE	1,691
4,496	4,496	MISC. M.I.S. EXPE	15,886
4,510	4,510	REAL ESTATE TA	0
4,600	4,600	LEASED EQUIPME	15,138
5,110	5,110	MAINTENANCE W	89,653
5,120	5,120	MAINTENANCE PT	5,582
5,130	5,130	ELECTRIC	47,055
5,131	5,131	NATURAL GAS	20,972
5,133	5,133	WATER & SEWER	28,863
5,134	5,134	TRASH COLLECTI	10,597
5,140	5,140	PROP/PLANT REF	16,054
5,160	5,160	GENERAL REPAIR	45,148
5,165	5,165	MAINTENANCE C(	17,426
5,210	5,210	DIETARY WAGES	254,828
5,220	5,220	DIETARY PTO & R	22,404
5,248	5,248	FOOD PURCHASE	189,955
5,250	5,250	SUPPLIES DISHW	8,287
5,260	5,260	REPLACEMENT-D	1,805
5,270	5,270	KITCHEN SUPPLIE	9,963
5,295	5,295	MEAL INCOME	(1,700)
5,310	5,310	LAUNDRY WAGES	65,618
5,340	5,340	LAUNDRY PTO & I	3,452
5,370	5,370	REPLACEMENT-L.	9,325
5,380		DIETARY CONSUI	8,489
5,390	5,390	SUPPLIES	6,934
5,410	5,410	HOUSEKEEPING \	107,662
5,440	5,440	HOUSEKEEPING I	9,433
5,480	5,480	SUPPLIES-CLEAN	42,784
5,490	5,490	SUPPLIES-HOUSE	0
6,020	6,020	RN WAGES	682,337
6,030	6,030	DON WAGES	73,377
6,035	6,035	ADON WAGES	58,266
6,040	6,040	RN PTO & RESER	44,094
6,120	6,120	LPN WAGES	354,596
6,140	6,140	LPN PTO & RESEI	35,067
6,220	6,220	AIDES WAGES	820,239
6,240	6,240	AIDES PTO & RES	45,436
6,245		RN REGISTRY	0
6,246		LPN REGISTRY	0
6,247		AIDES REGISTRY	0
6,250			0
6,255			0
6,260			0
6,270	6,270	REHAB WAGES	40,041
6,275	6,275	REHAB PTO & RE	3,021
6,290	6,290	NURSING SUPPLI	40,600
6,295	6,295	NURSING SUPPLI	122,353
6,390	6,390	REPLACEMENT-N	5,432
6,490	6,490	OTHER	4,873
7,280	7,280	DRUG PURCHASE	568,260
7,281	7,281	DRUG PURCHASE	0
7,380	7,380	LABORATORY SE	25,664
7,391	7,390	X-RAY SERVICES	18,122
7,393			17,713
7,510	7,510	ACTIVITIES WAGE	63,669
7,540	7,540	ACTIVITIES PTO 8	3,893
7,590	7,590	ACTIVITIES SUPP	429
7,620	7,620	PHYSICAL THERA	332,476
7,660	7,660	P.T. SUPPLY - BIL	1,380
7,710	7,710	SOCIAL SERVICE	41,914
7,720	7,720	SOCIAL SERVICE	4,399
7,730	7,730	SOCIAL SERVICE-	0
7,740	7,740	OCCUPATIONAL T	440,390
7,750			
7,770	7,770	SPEECH THERAP	81,495
7,820	7,820	BEAUTICIAN FEE	2,318
7,890			0
7,960			0
8,120	8,120	INTEREST	0
8,125			48,284
8,130	8,130	DEPRECIATION	0
8,150			0
9,510	9,510	INTEREST INCOM	(3,370)
9,520	9,520	MISC NON-OPER/	0
9,530	4,220		0
	8,100		373,632
	9,702		0
	5,230		0
			(41,064)

Expenses Fixed Assets 0

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 88

BALANCE SHEET TOTAL 0

G/L RECAP CENSUS

Heritage Manor - Danville
IDPH ID# 53413
HFS Cost Report - December 31, 2018
Schedule V - Column 5 Reclassifications

1. Schedule V - Line 10a to Line 39 - Reclassifications

Line Item		
Purchased Drugs and Medications	$	568,261
Purchased Hospital Services		17,712
Purchased Laboratory Services		25,664
Purchased Radiology Services		18,122
Amount Reclassified to Line 39	$	629,759

2. Schedule V - Line 20 to Line 42 - Reclassification

Line Item		
Provider Participation Fee - $1.50	$	(49,275)
Provider Assesment Fee - $6.07		(120,520)
		(169,795)
Provider Participation Fee - Line 42		169,795