



Facility Name & ID Number Colonial Manor

# 42168 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	9,471	11,508	6,012	26,991	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,471	11,508	6,012	26,991	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.09%

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

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

I. On what date did you start providing long term care at this location?  
Date started 1996

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 6,012

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  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: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	242,883	29,093		271,976		271,976	3,236	275,212		1
2	Food Purchase		164,263		164,263		164,263	1	164,264		2
3	Housekeeping	107,175	37,257		144,432		144,432		144,432		3
4	Laundry	89,221	12,578		101,799		101,799		101,799		4
5	Heat and Other Utilities			112,201	112,201		112,201	1,658	113,859		5
6	Maintenance	87,760	120,085	84,432	292,277		292,277	16,525	308,802		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	527,039	363,276	196,633	1,086,948		1,086,948	21,420	1,108,368		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400	1,609	10,009		9
10	Nursing and Medical Records	1,803,891	177,680	5,629	1,987,200		1,987,200		1,987,200		10
10a	Therapy		494,183	721,044	1,215,227	(577,305)	637,922	(54,034)	583,888		10a
11	Activities	83,955	6,296		90,251		90,251	720	90,971		11
12	Social Services	20,371		3,967	24,338		24,338		24,338		12
13	CNA Training							1,177	1,177		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,908,217	678,159	739,040	3,325,416	(577,305)	2,748,111	(50,528)	2,697,583		16
	<b>C. General Administration</b>										
17	Administrative	79,486			79,486		79,486		79,486		17
18	Directors Fees										18
19	Professional Services			257,673	257,673		257,673	(247,523)	10,150		19
20	Dues, Fees, Subscriptions & Promotions			67,056	67,056	(45,443)	21,613	(22)	21,591		20
21	Clerical & General Office Expenses	140,108	27,566	10,669	178,343		178,343	203,873	382,216		21
22	Employee Benefits & Payroll Taxes			513,725	513,725		513,725	26,769	540,494		22
23	Inservice Training & Education			5,069	5,069		5,069	838	5,907		23
24	Travel and Seminar			7,085	7,085		7,085	7,529	14,614		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,386	64,386		64,386	8,945	73,331		26
27	Other (specify):*			13,760	13,760		13,760	(13,725)	35		27
28	<b>TOTAL General Administration</b>	219,594	27,566	939,423	1,186,583	(45,443)	1,141,140	(13,316)	1,127,824		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,654,850	1,069,001	1,875,096	5,598,947	(622,748)	4,976,199	(42,424)	4,933,775		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 &amp; ID Number

Colonial Manor

#42168

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			123,689	123,689		123,689	7,871	131,560			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			192,501	192,501		192,501	(5,255)	187,246			32
33	Real Estate Taxes			112,075	112,075		112,075		112,075			33
34	Rent-Facility & Grounds			8,493	8,493		8,493	(4,253)	4,240			34
35	Rent-Equipment & Vehicles			6,137	6,137		6,137	1,368	7,505			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			442,895	442,895		442,895	(269)	442,626			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					577,305	577,305		577,305			39
40	Barber and Beauty Shops			5,700	5,700		5,700		5,700			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					45,443	45,443		45,443			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			5,700	5,700	622,748	628,448		628,448			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,654,850	1,069,001	2,323,691	6,047,542		6,047,542	(42,693)	6,004,849			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space	(910)	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	(5,531)	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)		23		16
17	Non-Care Related Fees	(396)	20		17
18	Fines and Penalties				18
19	Entertainment		24		19
20	Contributions	(1,725)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,351)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(6,232)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (30,145)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(12,548)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (12,548)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (42,693)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Colonial Manor

ID# 42168

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(396)	20	17
18				18
19			24	19
20		(1,725)	27	20
21				21
22		(3,351)	19	22
23				23
24		(12,000)	27	24
25		(6,232)	20	25
26				26
27				27
28				28
29		0	33	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(23,704)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Colonial Manor

# 42168

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	3,236	0	0	0	0	0	0	0	0	3,236	1
2	Food Purchase	0	0	1	0	0	0	0	0	0	0	0	1	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,658	0	0	0	0	0	0	0	0	1,658	5
6	Maintenance	0	0	16,525	0	0	0	0	0	0	0	0	16,525	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	21,420	0	0	0	0	0	0	0	0	21,420	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	1,609	0	0	0	0	0	0	0	0	1,609	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(54,034)	0	0	0	0	0	0	0	0	0	(54,034)	10a
11	Activities	0	0	720	0	0	0	0	0	0	0	0	720	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,177	0	0	0	0	0	0	0	0	1,177	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	(54,034)	3,506	0	0	0	0	0	0	0	0	(50,528)	16
	<b>C. General Administration</b>													
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	(3,351)	(254,322)	10,150	0	0	0	0	0	0	0	0	(247,523)	19
20	Fees, Subscriptions & Promotions	(6,628)	0	6,606	0	0	0	0	0	0	0	0	(22)	20
21	Clerical & General Office Expenses	0	0	203,873	0	0	0	0	0	0	0	0	203,873	21
22	Employee Benefits & Payroll Taxes	0	0	26,769	0	0	0	0	0	0	0	0	26,769	22
23	Inservice Training & Education	0	0	838	0	0	0	0	0	0	0	0	838	23
24	Travel and Seminar	0	0	7,529	0	0	0	0	0	0	0	0	7,529	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	8,945	0	0	0	0	0	0	0	0	8,945	26
27	Other (specify):*	(13,725)	0	0	0	0	0	0	0	0	0	0	(13,725)	27
28	<b>TOTAL General Administration</b>	(23,704)	(254,322)	264,710	0	0	0	0	0	0	0	0	(13,316)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(23,704)	(308,356)	289,636	0	0	0	0	0	0	0	0	(42,424)	29

## STATE OF ILLINOIS

Facility Name & ID Number Colonial Manor# 42168

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	7,871	0	0	0	0	0	0	0	7,871	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,531)	0	0	276	0	0	0	0	0	0	0	(5,255)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(910)	(8,493)	0	5,150	0	0	0	0	0	0	0	(4,253)	34
35	Rent-Equipment & Vehicles	0	0	0	1,368	0	0	0	0	0	0	0	1,368	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(6,441)</b>	<b>(8,493)</b>	<b>0</b>	<b>14,665</b>	<b>0</b>	<b>(269)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(30,145)	(316,849)	289,636	14,665	0	0	0	0	0	0	0	(42,693)	45

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(54,034)	(54,034)	2
3	V							3
4	V	19 Adjustment for Related Organization	254,322	Heritage Operations Group, LLC	0.00%		(254,322)	4
5	V							5
6	V	34 Adjustment for Related Organization	8,493	Heritage Manor Real Estate, LLC	0.00%		(8,493)	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		\$ 262,815			\$ (54,034)	\$ * (316,849)	14

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

Facility Name &amp; ID Number

Colonial Manor

# 42168

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	3,236 15
16	V	2 Food Purchase						1 16
17	V	3 Housekeeping						0 17
18	V	4 Laundry						0 18
19	V	5 Heat & Other Utilities						1,658 19
20	V	6 Maintenance						16,525 20
21	V	7 Other						0 21
22	V	9 Medical Director						1,609 22
23	V	10 Nursing & Medical Records						0 23
24	V	11 Activities						720 24
25	V	12 Social Service						0 25
26	V	13 Nurse Aide Training						1,177 26
27	V	14 Program Transportation						0 27
28	V	15 Other						0 28
29	V	17 Administrative						0 29
30	V	18 Directors Fees						0 30
31	V	19 Professional Services						10,150 31
32	V	20 Fees, Subscription, Promotions						6,606 32
33	V	21 Clerical & General Office Expenses						203,873 33
34	V	22 Employee Benefits & Payroll Taxes						26,769 34
35	V	23 Inservice Training & Education						838 35
36	V	24 Travel and Seminar						7,529 36
37	V	25 Other Admin. Staff Transportation						0 37
38	V	26 Insurance-Prop.Liab.Malpract						8,945 38
39	Total		\$			\$	0	\$ * 289,636 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	0 15
16	V	30 Depreciation						7,871 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						276 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						5,150 20
21	V	35 Rent-Equipment & Vehicles						1,368 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							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$	\$	0 \$ * 14,665 39

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

Facility Name & ID Number Colonial Manor # 42168 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					\$ 0	18/7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Colonial Manor

# 42168

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Heritage Operations Group

Street Address

box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

( )

Fax Number

( )

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 102,708	\$ 102,349	83	\$ 3,236	1
2	2	Food Purchase	Beds	2,634	25	29	0	83	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	83	0	3
4	4	Laundry	Beds	2,634	25	0	0	83	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	83	1,658	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	83	16,525	6
7	7	Other	Beds	2,634	25	0	0	83	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	83	1,609	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	83	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	83	720	10
11	12	Social Service	Beds	2,634	25	0	0	83	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	83	1,177	12
13	14	Program Transportation	Beds	2,634	25	0	0	83	0	13
14	15	Other	Beds	2,634	25	0	0	83	0	14
15	17	Administrative	Beds	2,634	25	0	0	83	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	83	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	83	10,150	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	83	6,606	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	83	203,873	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	83	26,769	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	83	838	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	83	7,529	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	83	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	83	8,945	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 289,636	25

Facility Name & ID Number Colonial Manor

# 42168

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	25	\$	83	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	83	7,871	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		83		3
4	32	Interest	Beds	2,634	25	8,747	83	276	4
5	33	Real Estate Taxes	Beds	2,634	25		83		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	83	5,150	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	83	1,368	7
8	36	Other	Beds	2,634	25		83		8
9	38	Medically Nec Transportation	Beds	2,634	25		83		9
10	39	Ancillary Service Centers	Beds	2,634	25		83		10
11	40	Barber and Beauty Shops	Beds	2,634	25		83		11
12	41	Coffee and Gift Shops	Beds	2,634	25		83		12
13	42	Other	Beds	2,634	25		83		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 465,371	\$	\$ 14,665	25

Facility Name & ID Number

Colonial Manor

# 42168

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Busey Bank		xx	Mortgage			\$	\$ 2,786,917	03/11	variable	\$ 179,164	1							
2	Busey Bank		xx	Loan Fees							3,597	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Bank of America		xx	Accounts Receivable							9,740	6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$	\$ 2,786,917			\$ 192,501	9							
<b>B. Non-Facility Related*</b>																			
10	Interest Income										(5,531)	10							
11	Allocated Corporate										276	11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (5,255)	14							
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 2,786,917			\$ 187,246	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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	<b>108,926</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>107,806</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,120)</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>113,195</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>112,075</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>80,837</b>	8	
	2005	<b>93,692</b>	9	
	2006	<b>107,707</b>	10	
	2007	<b>107,826</b>	11	
	2008	<b>112,075</b>	12	
				<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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



Facility Name & ID Number Colonial Manor

# 42168

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: 1, Use, Square Feet, Year Acquired, \$ 111,000, 1. Row 2: 2, Square Feet, Year Acquired, Cost, 2. Row 3: 3, TOTALS, \$ 111,000, 3.

Facility Name &amp; ID Number Colonial Manor

# 42168

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	83			\$ 1,709,475	\$		\$	\$	\$
5				33,000					
6									
7									
8									
	<b>Improvement Type**</b>								
9	Architect Fees		1997	46,312					
10	Property @ 607 Cunningham		1997	50,000					
11									
12	Architect Fees		1998	15,039					
13	Door Replacement		1998	6,993					
14	Water Pump		1998	1,439					
15	Generator Gaskets		1998	1,011					
16	Hallway Door		1998	800					
17	Canapy		1998	1,526					
18	Dumpster Pad		1998	4,100					
19	Iron Fence		1998	900					
20	Floor Drain		1998	800					
21	Railing		1998	900					
22	Addition--Materials		1998	762,036					
23	Addition--Labor		1998	48					
24	Addition--Professional Fees		1998	7,546					
25	Washer/Dryer Repair		1998	1,619					
26	Addition--Materials		1999	181,865					
27	Addition--Professional Fees		1999	3,782					
28	WAN Building Materials		1999	4,698					
29	Roof Repair		1999	1,783					
30									
31									
32									
33									
34	C/O Allocation						7,871	7,871	
35	Book Depreciation				92,262		92,262		1,036,627
36									

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Colonial Manor

# 42168

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Window Replacements	2000	\$ 3,005	\$		\$	\$	\$	37
38	Water Heater	2000	3,798						38
39									39
40	Nurse Call System	2001	24,949						40
41	Coax Cable	2001	945						41
42	Roof Sheathing	2001	1,314						42
43									43
44	Door Alarm	2002	2,383						44
45	Roof	2002	38,165						45
46	Water Heater	2002	3,656						46
47	Heater/Air Conditioning Unit	2002	1,843						47
48	Fire Dampers	2002	523						48
49	A/C Unit	2002	566						49
50	Security Door	2002	1,127						50
51	Dishwasher Motor	2002	1,129						51
52	Sealcoat Parking Lot	2002	1,955						52
53									53
54	Backflow Prevention	2003	672						54
55	Repair/Replace Doors	2003	7,866						55
56	A/C Unit	2003	495						56
57	Fire Supression System	2003	1,286						57
58									58
59	Automatic Transfer Switch	2004	3,458						59
60	Aero Air Condensor	2004	1,508						60
61	Parking Lot Sealant	2004	2,379						61
62									62
63	Kitchen Air Handler	2005	2,855						63
64	Condensor	2005	2,086						64
65	A/C Unit	2005	995						65
66	Ramp and Rails	2005	808						66
67	A/C Condensor	2005	2,313						67
68	Concrete	2005	1,714						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,949,465	\$ 92,262		\$ 100,133	\$ 7,871	\$ 1,036,627	70

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

Facility Name &amp; ID Number Colonial Manor

# 42168

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,949,465	\$ 92,262		\$ 100,133	\$ 7,871	\$ 1,036,627	1
2	Sprinkler	2006	11,094						2
3	Condensor	2006	2,324						3
4	A/C unit	2006	754						4
5	Roof	2006	1,900						5
6	Parking Lot	2006	2,379						6
7	Backflow preventer	2006	1,400						7
8	Sprinkler	2006	2,693						8
9	A/C unit	2006	1,161						9
10	Dry pendant	2006	1,010						10
11									11
12	Exhaust Fans	2007	674						12
13	Hot Water Liner	2007	700						13
14	HVAC	2007	9,599						14
15	Heat Coil	2007	2,776						15
16	HVAC condensor	2007	4,625						16
17	Fire Door	2007	600						17
18	Sprinkler system	2007	4,945						18
19	Front Pourch	2007	3,932						19
20	Room Repair	2007	980						20
21	Boiler	2007	5,257						21
22	Carpet	2007	615						22
23									23
24	Carpeting	2008	20,682						24
25	Basement Stairs	2008	2,694						25
26	Metal Doors	2008	2,510						26
27	A/C unit	2008	7,891						27
28	Air Handling Unit	2008	3,237						28
29	Fire System	2008	2,525						29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,048,422	\$ 92,262		\$ 100,133	\$ 7,871	\$ 1,036,627	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,048,422	\$ 92,262		\$ 100,133	\$ 7,871	\$ 1,036,627	1
2	2009	2,572						2
3	2009	8,250						3
4	2009	4,070						4
5	2009	2,969						5
6	2009	2,729						6
7	2009	7,368						7
8	2009	29,982						8
9	2009	4,050						9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,110,412	\$ 92,262		\$ 100,133	\$ 7,871	\$ 1,036,627	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:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 358,105	\$ 31,427	\$ 31,427	\$		\$ 277,655	71
72	Current Year Purchases	44,721						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 402,826	\$ 31,427	\$ 31,427	\$		\$ 277,655	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,624,238	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 123,689	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 131,560	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,871	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,314,282	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.  YES  NO

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

**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: \$ 6,137 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

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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 296,781	\$		\$ 296,781	1
2	Licensed Speech and Language Development Therapist		hrs			11,360			11,360	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			326,202	3,579		329,781	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				490,604		490,604	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					86,701			86,701	13
14	TOTAL			\$		\$ 721,044	\$ 494,183		\$ 1,215,227	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# 42168Report Period Beginning: 01/01/2009Ending: 12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 54,652	\$	1
2	Cash-Patient Deposits	3,588		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	737,638		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,466		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	130,455		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 946,799	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,000		13
14	Buildings, at Historical Cost	3,113,846		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	402,826		16
17	Accumulated Depreciation (book methods)	(1,314,282)		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): <u>goodwill</u>	1,108,048		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,421,438	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,368,237	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 127,691	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,588		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,096		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,048		31
32	Accrued Real Estate Taxes(Sch.IX-B)	113,195		32
33	Accrued Interest Payable	14,931		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 499,549	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,796,661		40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,796,661	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,296,210	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,072,027	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,368,237	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>835,259</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>835,259</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>236,768</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>236,768</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,072,027</b>	<b>24</b> *

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

Facility Name &amp; ID Number Colonial Manor

# 42168

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,017,776	1
2	Discounts and Allowances for all Levels	(3,023,424)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,994,352	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,509,190	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,509,190	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,045	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	910	16
17	Sale of Drugs	783,042	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(14,760)	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 775,237	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	5,531	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 5,531	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,284,310	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,086,948	31
32	Health Care	3,325,416	32
33	General Administration	1,186,583	33
<b>B. Capital Expense</b>			
34	Ownership	442,895	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	5,700	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,047,542	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	236,768	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 236,768	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: 01/01/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,048	2,160	\$ 82,379	\$ 38.14	1
2	Assistant Director of Nursing	1,808	2,160	48,737	22.56	2
3	Registered Nurses	14,163	15,583	383,305	24.60	3
4	Licensed Practical Nurses	25,026	26,818	540,582	20.16	4
5	CNAs & Orderlies	65,331	70,737	748,888	10.59	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	6,968	7,628	83,955	11.01	10
11	Social Service Workers	1,516	1,584	20,371	12.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,822	24,708	242,883	9.83	15
16	Dishwashers					16
17	Maintenance Workers	5,980	6,531	87,760	13.44	17
18	Housekeepers	10,901	9,689	107,175	11.06	18
19	Laundry	9,569	10,231	89,221	8.72	19
20	Administrator	1,900	2,080	79,486	38.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,108	9,033	140,108	15.51	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)	176,140	188,942	\$ 2,654,850 *	\$ 14.05	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	8,400		36
37	Medical Records Consultant	1,628		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,910		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	3,967		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 16,905		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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 &amp; ID Number Colonial Manor

# 42168

Report Period Beginning: 01/01/2009

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ 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. \$ 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? 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. \$ 1,331
- (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.