

Facility Name & ID Number COLONIAL MANOR

0044610 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 365

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	49	Intermediate/DD	49	17,885	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	16,026		83	16,109	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,026		83	16,109	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.07%

D. How many bed-hold days during this year were paid by the Department? 150 (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 2/1/2000

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/2000 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 49 and days of care provided 365

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number COLONIAL MANOR # 0044610 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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
	A. General Services										
1	Dietary	105,758	17,304	4,336	127,398		127,398		127,398		1
2	Food Purchase		117,543		117,543		117,543		117,543		2
3	Housekeeping	30,136	12,409	3,503	46,048		46,048		46,048		3
4	Laundry	21,032	7,540	44	28,616		28,616		28,616		4
5	Heat and Other Utilities			66,837	66,837		66,837		66,837		5
6	Maintenance	31,731	4,317	16,147	52,195		52,195		52,195		6
7	Other (specify):*										7
8	TOTAL General Services	188,657	159,113	90,867	438,637		438,637		438,637		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	231,685	38,366	12,540	282,591		282,591		282,591		10
10a	Therapy	596,860	10,886		607,746		607,746		607,746		10a
11	Activities		146		146		146		146		11
12	Social Services		419	1,450	1,869		1,869		1,869		12
13	CNA Training			785	785		785		785		13
14	Program Transportation			2,099	2,099		2,099		2,099		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	828,545	49,817	16,874	895,236		895,236		895,236		16
	C. General Administration										
17	Administrative	146,220			146,220		146,220		146,220		17
18	Directors Fees			6,633	6,633		6,633		6,633		18
19	Professional Services			1,900	1,900		1,900		1,900		19
20	Dues, Fees, Subscriptions & Promotions			2,039	2,039		2,039	(75)	1,964		20
21	Clerical & General Office Expenses		4,752	7,499	12,251		12,251		12,251		21
22	Employee Benefits & Payroll Taxes			164,953	164,953		164,953	(606)	164,347		22
23	Inservice Training & Education										23
24	Travel and Seminar			110	110		110		110		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			18,446	18,446		18,446		18,446		26
27	Other (specify):* Bank Charges			302	302		302	(4,736)	(4,434)		27
28	TOTAL General Administration	146,220	4,752	201,882	352,854		352,854	(5,417)	347,437		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,163,422	213,682	309,623	1,686,727		1,686,727	(5,417)	1,681,310		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

#0044610

Report Period Beginning:

01/01/2010

Ending:

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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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			13,537	13,537		13,537	(2,039)	11,498			30
31	Amortization of Pre-Op. & Org.			103	103		103		103			31
32	Interest			13,658	13,658		13,658		13,658			32
33	Real Estate Taxes			15,704	15,704		15,704		15,704			33
34	Rent-Facility & Grounds			210,000	210,000		210,000	(217,650)	(7,650)			34
35	Rent-Equipment & Vehicles			2,212	2,212		2,212		2,212			35
36	Other (specify):* Fed.Inc.Tax			(24,356)	(24,356)		(24,356)		(24,356)			36
37	TOTAL Ownership			230,858	230,858		230,858	(219,689)	11,169			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,614	109,614		109,614		109,614			42
43	Other (specify):* Day Train Exp.			610,407	610,407		610,407	(610,407)				43
44	TOTAL Special Cost Centers			720,021	720,021		720,021	(610,407)	109,614			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,163,422	213,682	1,260,502	2,637,606		2,637,606	(835,513)	1,802,093			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

0044610

Report Period Beginning:

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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				5
6	Rented Facility Space	(7,650)	34-7		6
7	Sale of Supplies to Non-Patients	(420)	22-7		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,039)	30-7		9
10	Interest and Other Investment Income	(4,736)	27-7		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				17
18	Fines and Penalties				18
19	Entertainment	(186)	22-7		19
20	Contributions	(75)	20-7		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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 Day Train Income	(610,407)	43-7		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (625,513)		\$	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)	(210,000)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (210,000)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (835,513)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY

48		49		50		51		52	
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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Straight Line Depreciation	\$ (2,039)	30-7	1
2	Contributions	(75)	20-7	2
3	Day Train Income	(610,407)	43-7	3
4	Handling Fee Income	(4,736)	27-7	4
5	Rent Income	(7,650)	34-7	5
6	Rent Expense	(210,000)	34-7	6
7	Equipment-Sale to Staff	(420)	22-7	7
8	Staff Gifts-Christmas	(186)	22-7	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(835,513)		49

STATE OF ILLINOIS

Facility Name & ID Number COLONIAL MANOR

0044610

Report Period Beginning:

01/01/2010 Ending:

Summary B

12/31/2010

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(210,000)	0	0	0	0	0	0	0	0	0	(210,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	(210,000)	0	(210,000)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	(210,000)	0	(210,000)	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
Melissa Moore	80					
Greg Moore	20					

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	34 Lease Expense	\$ 210,000	Colonial Manor Land Trust	10000.00%	\$	\$	(210,000) 1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 210,000			\$	\$ *	(210,000) 14

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

Facility Name & ID Number

COLONIAL MANOR

0044610

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	Melissa Moore	Corp. Pres.	Adm.	80.00		20	50.00	Adm/Acct	\$ 26,632	17-1	1
2	Greg Moore		Adm.	20.00		40	100.00	Adm/Acct	33,574	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 60,206		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

0044610

Report Period Beginning:

01/01/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

COLONIAL MANOR

0044610

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6	Bank of Marion		x	Revolving Line of Credit		4/28/05	500,000		4/28/11	6.5000	13,658	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 500,000	\$			\$ 13,658	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 500,000	\$			\$ 13,658	15						

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

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

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

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Report Period Beginning:

01/01/2010 Ending:

12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,942 B. General Construction Type: Exterior Brick/Block Frame Block Number of Stories 1

C. Does the Operating Entity? (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? (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).

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

1. Total Amount Incurred: 1,048 2. Number of Years Over Which it is Being Amortized: 5
 3. Current Period Amortization: 103 4. Dates Incurred: 4/28/05

Nature of Costs: License/Fees/Applications-733

(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	<u>Building Site</u>	<u>125,104</u>	<u>2000</u>	<u>\$ 15,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	125,104		\$ 15,000	3

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	49	2000	1975	\$ 1,375,228	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Sink	2000		866	58	15	58		609
10	Exterior Paint	2001		4,121	275	15	275		2,612
11	Plumbing	2001		4,471	298	15	298		2,831
12	Guttering	2001		6,826	455	15	455		4,322
13	Kitchen Wall	2002		2,840	133	15	189	56	1,607
14	Storage Cabinets	2005		1,400	93	15	93		512
15	Sidewalks	2005		1,025	68	15	68		374
16	Nursing Station	2005		2,861	191	15	191		1,050
17	Fire Damange	2007		2,087	139	15	139		486
18	Living Room Furniture	2008		1,407		7	201	201	536
19	Bath/Shower/Tub Rooms	2010		8,867	443	15	493	50	493
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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	
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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,411,999	\$ 2,153		\$ 2,460	\$ 307	\$ 15,432	70

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

Facility Name & ID Number COLONIAL MANOR

0044610

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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	\$ 18,127	\$ 1,310	\$ 2,712	\$ 1,402	5 to 7	\$ 8,596	71
72	Current Year Purchases	9,872	9,872	475	(9,397)	5 to 7	475	72
73	Fully Depreciated Assets	127,674	202	5,851	5,649	5 to 7	127,674	73
74								74
75	TOTALS	\$ 155,673	\$ 11,384	\$ 9,038	\$ (2,346)		\$ 136,745	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	Healthcare	1997 Ford Van	2000	\$ 20,000	\$	\$	\$		\$ 20,000	76
77										77
78										78
79										79
80	TOTALS			\$ 20,000	\$	\$	\$		\$ 20,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,602,672	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 13,537	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,498	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,039)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 172,177	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: **Colonial Manor Land Trust**

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:	1975	49		\$ 210,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		49		\$ 210,000			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: \$ **2,212** Description: **Copy Machine-1236 Dishwasher-976**

(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 **2/1/2000**

Ending **2/1/2020**

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. **12/31/2011** \$ **210,000**

13. **12/31/2012** \$ **210,000**

14. **12/31/2013** \$ **210,000**

* 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 checked="" 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 <u>48</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>90</u></p>
--	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>4</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

- (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	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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

0044610

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 50,055	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	155,739		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,455		6
7	Other Prepaid Expenses	7,649		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>A/R-Misc.</u>	2,128		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 217,026	\$	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	36,774		15
16	Equipment, at Historical Cost	175,673		16
17	Accumulated Depreciation (book methods)	(189,807)		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)	\$ 22,640	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 239,666	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 12,859	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	16,010		31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Garnishments Payable</u>	262		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 44,631	\$	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)	\$ 81,500	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 126,131	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 113,535	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 239,666	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 205,785	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 205,785	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(92,250)	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)	\$ (92,250)	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)	\$ 113,535	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number COLONIAL MANOR

0044610

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,922,143	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,922,143	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	7,650	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	420	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,070	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,736	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,736	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Day Train Income</u>	610,407	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 610,407	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,545,356	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	438,637	31
32	Health Care	895,236	32
33	General Administration	352,854	33
B. Capital Expense			
34	Ownership	230,858	34
C. Ancillary Expense			
35	Special Cost Centers	610,407	35
36	Provider Participation Fee	109,614	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,637,606	40
41	Income before Income Taxes (line 30 minus line 40)**	(92,250)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (92,250)	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**

0044610

Report Period Beginning: **01/01/2010**

Ending:

12/31/2010

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	1,920	2,080	\$ 48,800	\$ 23.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	10,381	10,645	182,886	17.18	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,769	1,809	20,560	11.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,337	9,521	85,198	8.95	15
16	Dishwashers					16
17	Maintenance Workers	1,920	2,080	31,731	15.26	17
18	Housekeepers	3,657	3,657	30,137	8.24	18
19	Laundry	2,282	2,354	21,032	8.93	19
20	Administrator	1,920	2,080	64,617	31.07	20
21	Assistant Administrator	3,000	3,120	60,206	19.30	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,158	2,222	21,397	9.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	1,789	1,869	20,018	10.71	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	56,773	57,917	576,840	9.96	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,906	99,354	\$ 1,163,422 *	\$ 11.71	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	153	\$ 3,836	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	41	1,845	10a-3	40
41	Occupational Therapy Consultant	41	3,337	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	52	3,145	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	73	2,560	10a-3	45
46	Other(specify) <u>Dental Consultant</u>	40	3,990	10-3	46
47	<u>Psychologist Consultant</u>	40	3,050	10-3	47
48	<u>Psychiatry Consultant</u>	22	5,500	10-3	48
49	TOTAL (lines 35 - 48)	462	\$ 27,263		49

C. CONTRACT NURSES

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

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? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 5-10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (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. \$ 109,614
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? no Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - 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? n/a
 - 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? no
Firm Name: _____
- (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? n/a
Attach invoices and a summary of services for all architect and appraisal fees.