

		FOR BHF USE					

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**2013**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2013)**

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

<p><b>I. IDPH License ID Number:</b> <u>0042168</u></p> <p><b>Facility Name:</b> <u>Colonial Manor</u></p> <p><b>Address:</b> <u>620 Warrington Ave</u> <u>Danville</u> <u>61832</u>  Number City Zip Code</p> <p><b>County:</b> <u>Vermillion</u></p> <p><b>Telephone Number:</b> <u>( 217 ) 446-0660</u> Fax # ( )</p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>1977</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____ </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  Name: <u>Dave Underwood</u> Telephone Number: <u>( 309 ) 823-7135</u>  Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/13</u> to <u>12/31/13</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>David M. Underwood</u> (Title) <u>Sr. VP &amp; CFO</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) Fax # ( )</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David M. Underwood</u> (Title) <u>Sr. VP &amp; CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>David M. Underwood</u> (Title) <u>Sr. VP &amp; CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) Fax # ( )							

Facility Name & ID Number Colonial Manor

# 0042168 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,435	10,013	5,172	25,620	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,435	10,013	5,172	25,620	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.57%

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 1977

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 5,172

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL  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 &amp; ID Number

Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	258,953	4,853		263,806		263,806	5,849	269,655		1
2	Food Purchase		183,429		183,429		183,429	25	183,454		2
3	Housekeeping	98,629	46,844		145,473		145,473	3	145,476		3
4	Laundry	113,488	12,865		126,353		126,353		126,353		4
5	Heat and Other Utilities			91,760	91,760		91,760	1,284	93,044		5
6	Maintenance	100,672	129,565	71,001	301,238		301,238	12,697	313,935		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	571,742	377,556	162,761	1,112,059		1,112,059	19,858	1,131,917		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,706,104	163,720	7,652	1,877,476		1,877,476	2,266	1,879,742		10
10a	Therapy		488,656	654,737	1,143,393	(531,753)	611,640		611,640		10a
11	Activities	67,910	5,682		73,592		73,592		73,592		11
12	Social Services	49,154		3,496	52,650		52,650		52,650		12
13	CNA Training							490	490		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,823,168	658,058	677,885	3,159,111	(531,753)	2,627,358	2,756	2,630,114		16
	<b>C. General Administration</b>										
17	Administrative	86,181			86,181		86,181		86,181		17
18	Directors Fees										18
19	Professional Services			265,796	265,796		265,796	(249,494)	16,302		19
20	Dues, Fees, Subscriptions & Promotions			62,661	62,661	(45,443)	17,218	3,730	20,948		20
21	Clerical & General Office Expenses	211,391	19,536	16,774	247,701		247,701	242,651	490,352		21
22	Employee Benefits & Payroll Taxes			492,855	492,855		492,855	36,818	529,673		22
23	Inservice Training & Education			6,974	6,974		6,974	493	7,467		23
24	Travel and Seminar			4,689	4,689		4,689	(2,690)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			58,437	58,437		58,437	9,195	67,632		26
27	Other (specify):*			12,897	12,897		12,897	(12,000)	897		27
28	<b>TOTAL General Administration</b>	297,572	19,536	921,083	1,238,191	(45,443)	1,192,748	28,703	1,221,451		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,692,482	1,055,150	1,761,729	5,509,361	(577,196)	4,932,165	51,317	4,983,482		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

#0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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			157,963	157,963		157,963	15,573	173,536			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			127,234	127,234		127,234	(14,758)	112,476			32
33	Real Estate Taxes			83,272	83,272		83,272		83,272			33
34	Rent-Facility & Grounds			7,692	7,692		7,692	4,636	12,328			34
35	Rent-Equipment & Vehicles			20,814	20,814		20,814	3,907	24,721			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			396,975	396,975		396,975	9,358	406,333			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					531,753	531,753	(112,446)	419,307			39
40	Barber and Beauty Shops			6,550	6,550		6,550		6,550			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>			6,550	6,550	577,196	583,746	(112,446)	471,300			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,692,482	1,055,150	2,165,254	5,912,886		5,912,886	(51,771)	5,861,115			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				5
6	Rented Facility Space	(855)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(15,112)			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	(232)			17
18	Fines and Penalties				18
19	Entertainment	(8,509)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,643)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)			24
25	Fund Raising, Advertising and Promotional	(4,567)			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>	\$ (43,918)		\$	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)	(7,853)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (7,853)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (51,771)		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# 0042168

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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		0	33	15
16			24	16
17		(232)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(2,643)	19	22
23				23
24		(12,000)	27	24
25		(4,567)	20	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	<b>Total</b>		(19,442)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

## 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	5,849	0	0	0	0	0	0	0	0	5,849	1
2	Food Purchase	0	0	25	0	0	0	0	0	0	0	0	25	2
3	Housekeeping	0	0	3	0	0	0	0	0	0	0	0	3	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,284	0	0	0	0	0	0	0	0	1,284	5
6	Maintenance	0	0	12,697	0	0	0	0	0	0	0	0	12,697	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	19,858	0	0	0	0	0	0	0	0	19,858	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	2,266	0	0	0	0	0	0	0	0	2,266	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	490	0	0	0	0	0	0	0	0	490	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	0	2,756	0	0	0	0	0	0	0	0	2,756	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	(2,643)	(263,153)	16,302	0	0	0	0	0	0	0	0	(249,494)	19
20	Fees, Subscriptions & Promotions	(4,799)	0	8,529	0	0	0	0	0	0	0	0	3,730	20
21	Clerical & General Office Expenses	0	0	242,651	0	0	0	0	0	0	0	0	242,651	21
22	Employee Benefits & Payroll Taxes	0	0	36,818	0	0	0	0	0	0	0	0	36,818	22
23	Inservice Training & Education	0	0	493	0	0	0	0	0	0	0	0	493	23
24	Travel and Seminar	(8,509)	0	5,819	0	0	0	0	0	0	0	0	(2,690)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	9,195	0	0	0	0	0	0	0	0	9,195	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	<b>TOTAL General Administration</b>	(27,951)	(263,153)	319,807	0	0	0	0	0	0	0	0	28,703	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(27,951)	(263,153)	342,421	0	0	0	0	0	0	0	0	51,317	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Colonial Manor

# 0042168

Report Period Beginning:

01/01/13 Ending:

12/31/13

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	15,573	0	0	0	0	0	0	0	15,573	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,112)	0	0	354	0	0	0	0	0	0	0	(14,758)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(855)	0	0	5,491	0	0	0	0	0	0	0	4,636	34
35	Rent-Equipment & Vehicles	0	0	0	3,907	0	0	0	0	0	0	0	3,907	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(15,967)</b>	<b>0</b>	<b>0</b>	<b>25,325</b>	<b>0</b>	<b>9,358</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	(112,446)	0	0	0	0	0	0	0	0	0	(112,446)	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>(112,446)</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>(112,446)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(43,918)</b>	<b>(375,599)</b>	<b>342,421</b>	<b>25,325</b>	<b>0</b>	<b>(51,771)</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

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

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		
	V		\$			\$		1
2	V	<u>39 Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>(112,446)</u>	<u>(112,446)</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>263,153</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(263,153)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>			6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>				7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>				8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>				9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>				10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		<b>\$ 263,153</b>			<b>\$ (112,446)</b>	<b>\$ * (375,599)</b>	14

\* 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	1 Dietary	\$	Heritage Enterprises, Inc.		\$	\$ 5,849	15
16	V	2 Food Purchase					25	16
17	V	3 Housekeeping					3	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,284	19
20	V	6 Maintenance					12,697	20
21	V	7 Other					0	21
22	V	9 Medical Director					0	22
23	V	10 Nursing & Medical Records					2,266	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					490	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					16,302	31
32	V	20 Fees, Subscription, Promotions					8,529	32
33	V	21 Clerical & General Office Expenses					242,651	33
34	V	22 Employee Benefits & Payroll Taxes					36,818	34
35	V	23 Inservice Training & Education					493	35
36	V	24 Travel and Seminar					5,819	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					9,195	38
39	Total		\$			\$	0	\$ * 342,421 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.		\$	\$	15
16	V	30 Depreciation					15,573	16
17	V	31 Amortization of Pre-Op & Org					0	17
18	V	32 Interest					354	18
19	V	33 Real Estate Taxes					0	19
20	V	34 Rent-Facility & Grounds					5,491	20
21	V	35 Rent-Equipment & Vehicles					3,907	21
22	V	36 Other					0	22
23	V	38 Medically Nec Transportation					0	23
24	V	39 Ancillary Service Centers					0	24
25	V	40 Barber and Beauty Shops					0	25
26	V	41 Coffee and Gift Shops					0	26
27	V	42 Other					0	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ * 25,325 39

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

Facility Name & ID Number

Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

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

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

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					\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending: 12/31/13

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	2,604	24	\$ 183,508	\$ 183,106	83	\$ 5,849	1
2	2	Food Purchase	Beds	2,604	24	798	0	83	25	2
3	3	Housekeeping	Beds	2,604	24	106	0	83	3	3
4	4	Laundry	Beds	2,604	24	0	0	83	0	4
5	5	Heat & Other Utilities	Beds	2,604	24	40,282	0	83	1,284	5
6	6	Maintenance	Beds	2,604	24	398,350	84,311	83	12,697	6
7	7	Other	Beds	2,604	24	0	0	83	0	7
8	9	Medical Director	Beds	2,604	24	0	0	83	0	8
9	10	Nursing & Medical Records	Beds	2,604	24	71,096	69,815	83	2,266	9
10	11	Activities	Beds	2,604	24	0	0	83	0	10
11	12	Social Service	Beds	2,604	24	0	0	83	0	11
12	13	Nurse Aide Training	Beds	2,604	24	15,364	15,279	83	490	12
13	14	Program Transportation	Beds	2,604	24	0	0	83	0	13
14	15	Other	Beds	2,604	24	0	0	83	0	14
15	17	Administrative	Beds	2,604	24	0	0	83	0	15
16	18	Directors Fees	Beds	2,604	24	0	0	83	0	16
17	19	Professional Services	Beds	2,604	24	511,456	0	83	16,302	17
18	20	Fees, Subscription, Promotions	Beds	2,604	24	267,591	0	83	8,529	18
19	21	Clerical & General Office Expens	Beds	2,604	24	7,612,820	7,140,260	83	242,651	19
20	22	Employee Benefits & Payroll Tax	Beds	2,604	24	1,155,097	0	83	36,818	20
21	23	Inservice Training & Education	Beds	2,604	24	15,452	0	83	493	21
22	24	Travel and Seminar	Beds	2,604	24	182,552	0	83	5,819	22
23	25	Other Admin. Staff Transportatio	Beds	2,604	24	0	0	83	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,604	24	288,473	0	83	9,195	24
25	TOTALS					\$ 10,742,945	\$ 7,492,771		\$ 342,421	25

Facility Name & ID Number Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending: 12/31/13

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	27	Other	Beds	2,604	24	\$	\$	83	\$	1
2	30	Depreciation	Beds	2,604	24	488,578	83	15,573		2
3	31	Amortization of Pre-Op & Org	Beds	2,604	24		83			3
4	32	Interest	Beds	2,604	24	11,093	83	354		4
5	33	Real Estate Taxes	Beds	2,604	24		83			5
6	34	Rent-Facility & Grounds	Beds	2,604	24	172,279	83	5,491		6
7	35	Rent-Equipment & Vehicles	Beds	2,604	24	122,579	83	3,907		7
8	36	Other	Beds	2,604	24		83			8
9	38	Medically Nec Transportation	Beds	2,604	24		83			9
10	39	Ancillary Service Centers	Beds	2,604	24		83			10
11	40	Barber and Beauty Shops	Beds	2,604	24		83			11
12	41	Coffee and Gift Shops	Beds	2,604	24		83			12
13	42	Other	Beds	2,604	24		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					\$ 794,529	\$		\$ 25,325	25

Facility Name & ID Number

Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

**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	Name of Lender	2		3	4	5	6		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		x	Mortgage			\$	\$ 2,376,006			\$ 107,144	1					
2	Busey Bank		x	Loan Fee Amortization							2,578	2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6	Bank of America										17,512	6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$	\$ 2,376,006			\$ 127,234	9					
<b>B. Non-Facility Related*</b>																	
10	Interest Income										(15,112)	10					
11												11					
12	Allocated Corporate										354	12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (14,758)	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 2,376,006			\$ 112,476	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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2012 report.		\$	<b>96,925</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>87,901</b>	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(9,024)</b>	3															
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>92,296</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>83,272</b>	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2008	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____	13	14	PLUS APPEAL COST FROM LINE 5 \$ _____	14	15	LESS REFUND FROM LINE 6 \$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2012 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2009	_____	9																
	2010	<b>109,206</b>	10																
	2011	<b>74,431</b>	11																
	2012	<b>83,272</b>	12																

**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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Colonial Manor COUNTY Vermillion

FACILITY IDPH LICENSE NUMBER 0042168

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>23011020150060</u>	_____	\$ <u>67,029.00</u>	\$ <u>67,029.00</u>
2. <u>23071020190030</u>	_____	\$ <u>188.00</u>	\$ <u>188.00</u>
3. <u>23071020250060</u>	_____	\$ <u>17,315.00</u>	\$ <u>17,315.00</u>
4. <u>23071020130600</u>	_____	\$ <u>1,768.00</u>	\$ <u>1,768.00</u>
5. <u>23071080010040</u>	_____	\$ <u>1,601.00</u>	\$ <u>1,601.00</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>87,901.00</u></u>	\$ <u><u>87,901.00</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Colonial Manor

# 0042168 Report Period Beginning:

01/01/13 Ending:

12/31/13

**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?  (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).

none

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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>111,000</u>	1
2					2
3	TOTALS			\$ <u>111,000</u>	3

Facility Name & ID Number Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20	1998 Additions		1998		768,055					
21										
22										
23										
24										
25										
26	Addition--Materials		1999		146,931					
27	Addition--Professional Fees		1999		3,782					
28	WAN Building Materials		1999		4,698					
29	Roof Repair		1999		1,783					
30										
31										
32										
33	C/O Allocation					15,573		15,573		
34	Book Depreciation					123,242		123,242		
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

Facility Name &amp; ID Number Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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							51
52	Sealcoat Parking Lot	2002	1,955						52
53									53
54	Blackflow Prevention	2003	672						54
55	Repair/Replace Doors	2003	7,866						55
56	A/C Unit	2003	495						56
57	Fire Supression System	2003	1,286						57
58									58
59	Automatic Transfer Switch	2004	3,458						59
60	Aero Air Condensor	2004	1,508						60
61	Parking Lot Sealant	2004	2,379						61
62									62
63	Kitchen Air Handler	2005	2,855						63
64	Condensor	2005	2,086						64
65	A/C Unit	2005	995						65
66	Ramp and Rails	2005	808						66
67	A/C Condensor	2005	2,313						67
68	Concrete	2005	1,714						68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,826,700	\$ 138,815		\$ 138,815	\$	\$	70

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

Facility Name &amp; ID Number Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	Totals from Page 12A, Carried Forward		\$ 2,826,700	\$ 138,815		\$ 138,815	\$	\$	1
2	Sprinkler	2006	11,094						2
3	Condensor	2006	2,324						3
4	A/C unit	2006	754						4
5	Roof	2006	1,900						5
6	Parking Lot	2006	2,379						6
7	Backflow preventer	2006	1,400						7
8	Sprinkler	2006	2,693						8
9	A/C unit	2006	1,161						9
10	Dry pendant	2006	1,010						10
11									11
12									12
13									13
14	HVAC	2007	9,599						14
15	Heat Coil	2007	2,776						15
16	HVAC condensor	2007	4,625						16
17									17
18	Sprinkler system	2007	4,945						18
19	Front Pouch	2007	3,932						19
20	Room Repair	2007							20
21	Boiler	2007	5,257						21
22									22
23									23
24	Carpeting	2008	20,547						24
25	Basement Stairs	2008	2,694						25
26	Metal Doors	2008	2,510						26
27	A/C unit	2008	7,891						27
28	Air Handling Unit	2008	3,237						28
29	Fire System	2008	2,525						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,921,953	\$ 138,815		\$ 138,815	\$	\$	34

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

Facility Name &amp; ID Number Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	Totals from Page 12B, Carried Forward		\$ 2,921,953	\$ 138,815		\$ 138,815	\$	\$	1
2									2
3	Emergency Backflow	2009	2,572						3
4	Gutters	2009	8,250						4
5	Awning	2009	4,070						5
6	Aurora Pump	2009	2,969						6
7	HVAC	2009	2,729						7
8	Doors	2009	7,368						8
9	Asphalt	2009	29,063						9
10	Windows	2009	4,050						10
11									11
12	HVAC	2010	2,816						12
13	Roof	2010	91,520						13
14	Windows	2010	4,050						14
15	fire control panel	2010	3,609						15
16									16
17									17
18	Nurse Call & Tech System	2011	304,131						18
19	Purchased office building next to nursing home	2011	41,838						19
20	Roof	2011	3,977						20
21	Concrete	2011	5,090						21
22	Windows * installation	2011	30,060						22
23	Steel door	2011	8,595						23
24	sign	2011	9,067						24
25	Building repair to install washer & dryer.	2011	2,938						25
26									26
27	Lighting Upgrade	2012	2,667						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,493,382	\$ 138,815		\$ 138,815	\$	\$	34

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

Facility Name & ID Number Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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		\$ 3,493,382	\$ 138,815		\$ 138,815	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 3,493,382	\$ 138,815		\$ 138,815	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 515,037	\$ 34,721	\$ 34,721	\$		\$	71
72	Current Year Purchases	16,285						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 531,322	\$ 34,721	\$ 34,721	\$		\$	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,135,704	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 173,536	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 173,536	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending: 12/31/13

**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	<b>TOTAL</b>				\$			7

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. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

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: \$ 20,814      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	<b>TOTAL</b>		\$	\$	21

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

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

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 314,462	\$		\$ 314,462	1
2	Licensed Speech and Language Development Therapist		hrs				4,906			4,906	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				288,281	3,991		292,272	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					484,665		484,665	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						47,088			47,088	13
14	<b>TOTAL</b>			\$			\$ 654,737	\$ 488,656		\$ 1,143,393	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# 0042168Report Period Beginning: 01/01/13

Ending:

12/31/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(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	\$ 203,418	\$	1
2	Cash-Patient Deposits	3,362		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	790,972		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,319		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	825,621		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,844,692	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	112,000		13
14	Buildings, at Historical Cost	3,691,407		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	531,322		16
17	Accumulated Depreciation (book methods)	(1,927,558)		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):	8,593		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,415,764	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,260,456	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 221,072	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,362		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,993		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,108		31
32	Accrued Real Estate Taxes(Sch.IX-B)	92,296		32
33	Accrued Interest Payable	8,900		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Assessment Tax</u>	65,283		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 645,014	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	2,376,006		39
40	Mortgage Payable			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</b> (sum of lines 39 thru 44)	\$ 2,376,006	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 3,021,020	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,239,436	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,260,456	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 975,023	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 975,023	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	264,413	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)	\$ 264,413	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,239,436	24 *

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

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,785,013	1
2	Discounts and Allowances for all Levels	(2,865,748)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,919,265</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,368,300	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,368,300</b>	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	716	12
13	Barber and Beauty Care	5,731	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	855	16
17	Sale of Drugs	874,100	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(6,780)	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 874,622</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	15,112	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 15,112</b>	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>	<b>\$ 6,177,299</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,112,059	31
32	Health Care	3,159,111	32
33	General Administration	1,238,191	33
<b>B. Capital Expense</b>			
34	Ownership	396,975	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	6,550	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>	<b>\$ 5,912,886</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>264,413</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 264,413</b>	43

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

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

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

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

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

Facility Name & ID Number Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	1,872	2,024	\$ 84,786	\$ 41.89	1
2	Assistant Director of Nursing	1,828	2,016	55,912	27.73	2
3	Registered Nurses	15,974	17,007	414,479	24.37	3
4	Licensed Practical Nurses	18,464	19,893	438,891	22.06	4
5	CNAs & Orderlies	61,234	65,835	712,036	10.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	5,360	5,635	67,910	12.05	10
11	Social Service Workers	2,650	2,938	49,154	16.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,473	23,077	258,953	11.22	15
16	Dishwashers					16
17	Maintenance Workers	6,379	6,897	100,672	14.60	17
18	Housekeepers	9,206	9,633	98,629	10.24	18
19	Laundry	10,825	11,646	113,488	9.74	19
20	Administrator	1,900	2,080	86,181	41.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,835	9,970	211,391	21.20	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)	166,000	178,651	\$ 2,692,482 *	\$ 15.07	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	12,000		36
37	Medical Records Consultant	1,714		37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,092		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	3,496		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,302		49

C. CONTRACT NURSES

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



XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Colonial Manor

# 0042168

Report Period Beginning:

01/01/13

Ending:

12/31/13

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ \_\_\_\_\_ Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ 4,189
- (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? \_\_\_\_\_  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? \_\_\_\_\_  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: 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.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Adjustment Line #	Amount
1009	PETTY CASH	203,418				1,009	1,009 PETTY C 203,418
1010	CASH IN BANK					1,100	1,100 ACCTS R 790,972
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR UNCOLLECTIBI
1100	ACCOUNTS RECEIVABLE	790,972				1,110	1,110 ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
1130	MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID 21,319
1145	A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
1200	PREPAID INSURANCE	21,319				1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY					1,409	1,409 LAND 112,000
1310	SUPPLIES INVENTORY					1,450	1,450 FURNITU 531,322
1409	LAND	112,000				1,460	(425,640)
1450	FURNITURE & EQUIPMENT	531,322				1,475	1,475 CODE AI 3,691,407
1460	ACCUM DEPR-FURN & EQU	-425,640				1,490	1,490 ACCUM (1,501,918)
1475	BUILDING & IMPROVEMEN	3,691,407				1,530	1,530 RESIDEN 3,362
1490	ACCUM DEPR-BUILDING	-1,501,918				1,550	1,550 LOAN FE 8,593
1530	RESIDENT FUNDS	3,362				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	8,593				1,850	1,850 INTERCC 825,621
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (221,072)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	825,621				2,100	2,100 ACCRUE (80,626)
2010	ACCOUNTS PAYABLE	-221,072				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-80,626				2,110	2,110 ACCRUE (167,367)
2110	ACCRUED VACATION PAY	-167,367				2,120	2,120 U.C. TAXES PAYABLE

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(6,108)	
2125	FICA TAX PAYABLE	-6,108	-6,108	2,130	2,130 FEDERAL W/H TAX PAYABLE		
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE		
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL		
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE RE		
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS		
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND		
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETI		
2240	UNITED WAY			2,246	2,250 401K W/H		
2245	GROUP INSURANCE PAYABLE			2,250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GARNISHMENT		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	(8,900)	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYI	(65,283)	
2300	ACCRUED INTEREST PAYA	-8,900		2,350	2,350 REAL ES	(92,296)	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-65,283		2,400	2,400 CURRENT PORTION OF LT DE		
2350	REAL ESTATE TAX PAYAB	-92,296		2,512	2,512 DUE TO I	(3,362)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	(2,376,006)	
2390	SECURITY DEPOSITS	0		2,600			
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2		
2393	HEART FUND/BAZAAR			2,625			
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DE		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINI	(975,023)	
2460	INCOME TAXES PAYABLE					net incom	(264,413)
2512	DUE TO RESIDENTS	-3,362					
2600	MORTGAGE PAYABLE	-2,376,006					
2650	EQUIPMENT LOAN PAYABLE					balance	<u>0</u>
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	-975,023					
2970	PROFIT/LOSS FOR PERIOD	-264,413					
3007.1	PATIENT DAYS-PRIVATE	10,013					3,007

3007.2	PATIENT DAYS-IPA	10,435						3,007
3007.3	PATIENT DAYS-MEDICARE	5,172						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-5,746,389	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	-28,660	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-874,100	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,368,300	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	2,865,748	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	-855		6	0	6	-855		3,530
3530	13 BEAUTY SHOP	-5,731		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	-175		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	-541		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-9,964		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	6,780		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	196,651	211,391	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	86,181	86,181	17	1	0	0		4,120
4115	VACATION & SICK - G&A	14,740		21	1	0	0		4,125
4120 4475	EMPLOYEE BENEFITS	8,695	492,855	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACATION	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP	0		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP	-833		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	19,536	19,536	21	2	0	0		4,275
4260	TELEPHONE	16,774	16,774	21	3	0	0 **		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	6,974	6,974	23	3	16	0		4,280
4280	GENERAL TRAVEL	2,870	4,689	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	0		24	3	19	0 ***		4,285
4285	EDUCATION & SEMINAR	1,819		24	3	19	-8,509		4,289
4290	HELP WANTED ADVERTISING	1,921	62,661	20	3	0	0 -45,443		4,290
4291	PROMOTIONAL ADVERTISING	2,511		20	3	25	-2,511		4,291
4292	PUBLIC RELATIONS	2,056		20	3	25	-2,056		4,292
4300	LICENSES & FEES	48,150		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	5,025		20	3	17	-232		4,310
4320	CONTRIBUTIONS	714		27	3	20	0		4,320
4350	PROFESSIONAL FEES	2,643	265,796	19	3	22	-2,643		4,350
4355	MEDICAL DIRECTOR	12,000	12,000	9	3	0	0		4,355
4360	UTILIZATION REVIEW	0		10	3	0	0		4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0		4,363

4362	MEDICAL RECORDS CONSI	1,714		10	3	0	0	4,364
4363	PHARMACIST FEES	5,092		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,496	3,496	12	3	0	0	4,383
4370	TV RENTAL	15,586		35	3	5	0	4,390
4380	INCOME TAXES		12,897	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,998		20	3	26	0	4,401
4400	PAYROLL TAXES	249,000		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,591		22	3	0	0	4,420
4410	GROUP INSURANCE	191,041		22	3	0	0	4,430
4420	LIABILITY INSURANCE	58,437	58,437	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	36,361		22	3	0	0 **	4,450
4450	CENTRAL OFFICE FEES	263,153		19	3	34	0	4,460
4460	BAD DEBTS	12,000		27	3	24	-12,000	4,461
4470	LOST ITEMS-RESIDENTS	183		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	83,272	83,272	33	3	0	0	4,486
4600	LEASED EQUIPMENT	5,228	20,814	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	92,279	100,672	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	8,393		6	1	0	0	4,510
5130	ELECTRIC	40,902	91,760	5	3	0	0	4,600
5131	NATURAL GAS	22,099		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	28,759		5	3	0	0	5,130
5134	TRASH COLLECTION	31,362	71,001	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	45,014	129,565	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	84,551		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	39,639		6	3	0	0	5,140
5210	DIETARY WAGES	240,285	258,953	1	1	0	0	5,160
5220	DIETARY SICK & VAC	18,668		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	187,618	183,429	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	3,426	4,853	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	692		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	735		1	2	0	0	5,260
5295	MEAL CREDIT	-4,189		2	2	0	0	5,270
5310	LAUNDRY WAGES	104,956	113,488	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	8,532		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	5,779	12,865	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	7,086		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	91,721	98,629	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	6,908		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	32,104	46,844	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	14,740		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,706,104	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	375,137		10	1	0	0	6,020
6030	DON WAGES	84,786		10	1	0	0	6,030
6035	ADON	55,912		10	1	0	0	6,035
6040	RN SICK & VACATION	39,342		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	404,870		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	34,021		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	665,755		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	46,281		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	0		10	1	0	0	6,390
6275	REHAB SICK & VAC	0		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	145,855	163,720	10	2	0	0	7,281
6295	NURSING SUPPLIES	8,331		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	9,534		10	2	0	0	7,391
6490	NURSING OTHER	846	7,652	10	3	0	0 ***	7,393
7280	DRUG PURCHASES	296,602	488,656	39	2	0	0	7,510
7281	DRUG PURCHASES-OTHER	188,063		39	2			7,540
7380	LABORATORY SERVICES	47,088	654,737	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	63,170	67,910	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	4,740		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	5,682	5,682	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0 ***	7,820
7620	PT FEES	288,281		39	3	0	0	7,890
7660	PT SUPPLIES	3,991		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	44,672	49,154	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	4,482		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0 ***	8,130
7740	OT FEE	314,462		39	3	0	0	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0 ***	9,510
7770	SPEECH THERAPY FEE	4,906		39	3	0	0	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	6,550	6,550	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	7,692	7,692	34	3	0	0	

8120	INTEREST EXPENSE	124,656	127,234	32	3	14	-15,112
8130	DEPRECIATION	157,963	157,963	30	3	9	0
8150	LOAN FEE AMORTIZATION	2,578		32	3	0	0
9510	INTEREST INCOME	-15,112		32	0	10	0
9520	MISC NON-OPERATING INC	0		0	0	0	0
9700	INCOME TAXES	0		0	0	0	0
		5,897,774	5,912,886				
			15,112				

GRAND TOTALS -264,413 -43,918  
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 83

BALANCE SHEET TOTAL 0

G/L

RECAP CENSUS

PP 10,013

10,013

IPA 10,435

10,435

medicare 5,172

5,172

25,620

IPA BEDHOLDS 0

PP BEDHOLDS 0

PP CONVERS 0

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT	10,435
3,007 PATIENT	5,172
	0

3,010 BASIC CH	(5,746,389)
3,020 BASIC CH	0
3,030 BASIC CH	0
	0
	0
	0
	0

3,080 NURSING	(28,660)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(874,100)
	0

3,110 PHYSICAL	(2,368,300)
	0
3,112 PHYSICAL	0
3,113 PHYSICAL	0
3,140 LABORATORY INCOME	0

3,152 ST/OT TH	0
3,153 ST/OT TH	0
3,185 REHAB/ISOLATION/OTHER CHG	
3,410 IPA/OTHE	0
3,411 MEDICAR	0
3,420 MEDICAR	2,836,106

3,520 RENT INC	(855)
3,530 BEAUTY :	(5,731)
	(175)
3,570 VENDING	(541)
3,590 EQUIPME	(9,964)
3,595 RESIDENT	6,780
3,600 MISC INC	0
4,110 G&A WAC	196,651
4,111 ADMINIS'	86,181
4,115 G&A PTO	14,740
4,120 EMPLOYE	9,270
4,130 EMPLOYE	0
4,135 EMPLOYE	(833)
4,250 OFFICE SI	9,820
4,255 POSTAGE	3,036
4,260 TELEPHO	16,774
4,275 TRAINING	6,974
	63
4,280 GENERAL	2,870
4,281 MEAL EX	0
4,285 EDUCATI	1,746
4,289 MEETING	73
4,290 HELP WA	1,921
4,291 PROMOTI	2,511
4,292 PUBLIC R	2,056
4,300 LICENSE	48,150
4,310 DUES & S	5,025
4,320 CONTRIB	714
4,350 PROFESSI	2,643
4,355 MEDICAL	12,000
	1,714
	5,092

4,364 SOCIAL S	3,496
4,370 TV RENTL	15,586
4,383 BACKGR	2,998
4,390 OTHER T	0
4,400 PAYROLL	249,000
4,401 PAYROLL	8,591
4,410 GROUP IN	191,041
4,420 LIABILIT	58,437
4,430 WORKMA	32,861
4,435 W/C-FIRS	2,428
4,436 DRUG TE	1,009
4,450 MANAGE	263,153
4,460 BAD DEB'	12,000
4,461 BAD DEB'	29,642
4,470 LOST ITE	183
4,475 UNIFORM	(575)
4,486 SERVICE	18,729
4,490 MISC EXP	908
4,496 MISC. M.I	6,680
4,510 REAL EST	83,272
4,600 LEASED F	5,228
5,110 MAINTEN	92,279
5,120 MAINTEN	8,393
5,130 ELECTRIC	40,902
5,131 NATURAL	22,099
5,133 WATER &	28,759
5,134 TRASH CO	31,362
5,140 PROP/PLA	45,014
5,160 GENERAL	84,551
5,165 MAINTEN	20,910
5,210 DIETARY	240,285
5,220 DIETARY	18,668
5,248 FOOD PUI	186,710

5,250 SUPPLIES	3,426
5,260 REPLACE	692
5,270 KITCHEN	735
5,295 MEAL INC	(4,189)
5,310 LAUNDRY	104,956
5,340 LAUNDRY	8,532
5,370 REPLACE	5,779
	0
5,390 SUPPLIES	7,086
5,410 HOUSEKE	91,721
5,440 HOUSEKE	6,908
5,480 SUPPLIES	32,104
5,490 SUPPLIES	14,740
6,020 RN WAGE	375,137
6,030 DON WAG	84,786
6,035 ADON WA	55,912
6,040 RN PTO &	39,342
6,120 LPN WAG	404,870
6,140 LPN PTO	34,021
6,220 AIDES WA	665,755
6,240 AIDES PT	46,281
	0
	0
	0
	0
6,270 REHAB W	0
6,275 REHAB P	0
6,290 NURSING	145,855
6,295 NURSING	8,331
6,390 REPLACE	9,534
6,490 OTHER	846

7,280 DRUG PU	296,602
7,281 DRUG PU	188,063
7,380 LABORA	17,861
7,390 X-RAY SE	5,574
	23,653
7,510 ACTIVITI	63,170
7,540 ACTIVITI	4,740
7,590 ACTIVITI	5,682
7,620 PHYSICAL	288,281
7,660 P.T. SUPP	3,991
7,710 SOCIAL S	44,672
7,720 SOCIAL S	4,482
7,730 SOCIAL S	0
7,740 OCCUPA	314,462
7,770 SPEECH T	4,906
7,820 BEAUTIC	6,550
	0
	0
8,120 INTEREST	107,144
	17,512
8,130 DEPRECL	157,963
	2,578
9,510 INTEREST	(15,112)
9,520 MISC NOI	0
4,220	0
8,100	7,692
9,702	0
5,230	0
	<u>(264,413)</u>

Expenses Fixed Assets



Related Parties  
From Page 6

FACILITY	MEDICAID NUMBER	STATE LICENSE NUMBER
<b>Owned SNFs</b>		
Heritage Health - South, IL	20-5300302001	48843
Heritage Health - Bloomington, IL	20-3904134001	48157
Heritage Health - Carlinville, IL	20-5508113001	48850
Heritage Health - Chillicothe, IL	20-5412664001	48868
Heritage Health - Dwight, IL	20-5412784001	50492
Heritage Health - Elgin, IL	20-3902154001	48132
Heritage Health - El Paso, IL	20-3903447001	48124
Heritage Health - Gibson City, IL	20-3902572001	48116
Heritage Health - Gillespie, IL	20-5428620001	48892
Heritage Health - LaSalle, IL	27-3741988001	51276
Heritage Health - Litchfield, IL	20-5508096001	48900
Heritage Health - Mendota, IL	20-3904038001	48108
Heritage Health - Minonka, IL	20-3903980001	48058
Heritage Health - Mt. Sterling, IL	20-3903543001	48041
Heritage Health - Mt. Zion, IL	20-3903622001	48074
Heritage Health - Normal, IL	20-3903883001	48082
Heritage Health - Pana, IL	20-5508128001	48884
Heritage Health - Peru, IL	20-3902978001	48090
Heritage Health - Staunton, IL	20-5437628001	48876
Heritage Health - Streator, IL	20-3902216001	48066
Barton W. Stone Jacksonville, IL	20-5298969002	48918
Danville Joint Ventures, IL	37-1357323001	42168
Heritage Health - Danville, IL	37-1359387001	41699
Cotillion Ridge, IL	37-1402726001	45138
Country Health - Danville, IL	37-6064916001	7880
Mason City Health Center, IL	37-1168043001	34256
St. Clara's Medical Center, IL	37-6075710001	50724
Vonderlieth Health Center, IL	37-0967671001	19976