

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0044610</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																																	
Facility Name: <u>Colonial Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																																	
Address: <u>300 Church Street</u> <u>Zeigler</u> <u>62999</u>																																																																			
Number City Zip Code																																																																			
County: <u>Franklin</u>																																																																			
Telephone Number: <u>618-596-6635</u> Fax # <u>618-984-7734</u>																																																																			
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td><u>03/14/12</u></td></tr><tr><td>(Type or Print Name) <u>Greg Moore</u></td><td>(Date)</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>Corp. Pres./Owner</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date)</td></tr><tr><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td colspan="2"></td><td>(Telephone) <u>()</u></td><td>Fax # <u>()</u></td></tr><tr><td colspan="2">Date of Initial License for Current Owners: <u>02/01/2000</u></td><td colspan="2" rowspan="5"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td></tr><tr><td colspan="2">Type of Ownership:</td></tr><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☒ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other</td><td>_____</td></tr><tr><td colspan="2">In the event there are further questions about this report, please contact:</td><td colspan="2"></td></tr><tr><td colspan="2">Name: <u>Gteg Moore</u></td><td colspan="2"></td></tr><tr><td colspan="2">Telephone Number: <u>618-528-5073</u></td><td colspan="2"></td></tr><tr><td colspan="2">Email Address: _____</td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	<u>03/14/12</u>	(Type or Print Name) <u>Greg Moore</u>	(Date)	Paid Preparer	(Title) <u>Corp. Pres./Owner</u>		(Signed) _____	(Date)	(Print Name and Title) _____		(Firm Name & Address) _____				(Telephone) <u>()</u>	Fax # <u>()</u>	Date of Initial License for Current Owners: <u>02/01/2000</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		Type of Ownership:		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☒ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other	_____	In the event there are further questions about this report, please contact:				Name: <u>Gteg Moore</u>				Telephone Number: <u>618-528-5073</u>				Email Address: _____			
Officer or Administrator of Provider	(Signed) _____				<u>03/14/12</u>																																																														
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Facility Name & ID Number Colonial Manor

0044610 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	14,933			14,933	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,933			14,933	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.49%

D. How many bed-hold days during this year were paid by the Department? 76 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO x

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

I. On what date did you start providing long term care at this location? Date started 02/01/2000

J. Was the facility purchased or leased after January 1, 1978? YES x Date 02/01/2000 NO

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

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCUAL x MODIFIED CASH* CASH*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011 * All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Colonial Manor # 0044610 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	99,259	11,957	3,329	114,545		114,545		114,545			1
2	Food Purchase		114,592		114,592		114,592		114,592			2
3	Housekeeping	23,585	12,989	2,663	39,237		39,237		39,237			3
4	Laundry	19,633	4,105	173	23,911		23,911		23,911			4
5	Heat and Other Utilities			52,959	52,959		52,959		52,959			5
6	Maintenance	32,885	1,818	16,629	51,332		51,332		51,332			6
7	Other (specify):*											7
8	TOTAL General Services	175,362	145,461	75,753	396,576		396,576		396,576			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	232,478	34,207	11,898	278,583		278,583		278,583			10
10a	Therapy	566,079		7,271	573,350		573,350		573,350			10a
11	Activities		381	4,592	4,973		4,973		4,973			11
12	Social Services		61	78	139		139		139			12
13	CNA Training											13
14	Program Transportation			2,813	2,813		2,813		2,813			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	798,557	34,649	26,652	859,858		859,858		859,858			16
	C. General Administration											
17	Administrative	144,106			144,106		144,106		144,106			17
18	Directors Fees											18
19	Professional Services			5,651	5,651		5,651		5,651			19
20	Dues, Fees, Subscriptions & Promotions			2,203	2,203		2,203	(35)	2,168			20
21	Clerical & General Office Expenses		5,030	8,333	13,363		13,363		13,363			21
22	Employee Benefits & Payroll Taxes			151,160	151,160		151,160	(652)	150,508			22
23	Inservice Training & Education											23
24	Travel and Seminar			205	205		205	(205)				24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			20,513	20,513		20,513		20,513			26
27	Other (specify):* bank charges			394	394		394	(6,462)	(6,068)			27
28	TOTAL General Administration	144,106	5,030	188,459	337,595		337,595	(7,354)	330,241			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,118,025	185,140	290,864	1,594,029		1,594,029	(7,354)	1,586,675			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.

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			10,952	10,952		10,952	1,786	12,738			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,143	4,143		4,143	(29,449)	(25,306)			32
33	Real Estate Taxes			15,324	15,324		15,324		15,324			33
34	Rent-Facility & Grounds			210,000	210,000		210,000	(217,650)	(7,650)			34
35	Rent-Equipment & Vehicles			2,150	2,150		2,150		2,150			35
36	Other (specify):* Fed.Inc.Tax			9,685	9,685		9,685		9,685			36
37	TOTAL Ownership			252,254	252,254		252,254	(245,313)	6,941			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			79,990	79,990		79,990		79,990			42
43	Other (specify):*			274,380	274,380		274,380	(274,380)				43
44	TOTAL Special Cost Centers			354,370	354,370		354,370	(274,380)	79,990			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,118,025	185,140	897,488	2,200,653		2,200,653	(527,047)	1,673,606			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(31)			4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(7,650)			6
7	Sale of Supplies to Non-Patients	(621)			7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,786			9
10	Interest and Other Investment Income	(29,449)			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	(6,462)			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	(205)			19
20	Contributions	(35)			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	(274,380)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (317,047)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(210,000)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (210,000)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (527,047)		37

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

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

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

Colonial Manor

ID#	0044610
Report Period Beginning:	01/01/11
Ending:	12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Straight Line Depreciation	\$ 1,786	30-7	1
2	Contribution	(35)	20-7	2
3	Day Train Income	(274,380)	43-7	3
4	Handling Fee Income	(6,462)	27-7	4
5	Rent Income	(7,650)	34-7	5
6	Rent Expense	(210,000)	34-7	6
7	Equipment-Sale to Staff	(621)	22-7	7
8	Interest Income	(29,188)	32-7	8
9	Travel/Entertainment	(205)	24-7	9
10	Staff Meal	(31)	22-7	10
11	Interest Charge-Hawkeye	(261)	32-7	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	(527,047)		49

Summary A

12/31/11

[illegible]

Summary B

12/31/11

[illegible]

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
Melissa Moore	50%					
Greg Moore	50%					

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)	
1	V	34	Lease Expense	\$ 210,000	Colonial Manor Land Trust	100.00%	\$	\$ (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.

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
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16								16
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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	2	3	4	5	6		7		8	
					Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
	Name	Title	Function	Ownership Interest		Hours	Percent	Description	Amount		
1	Melissa Moore	Secretary	Adm	50%`	0	40	1.00	Adm./Acct.	\$ 37,526	17-1	1
2	Greg Moore	Corp. Pres	Adm	0.50	0	40	1.00	Adm./Acct.	20,287	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	\$ 57,814		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: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	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	439,000				3,189	6
7													7
8													8
9	TOTAL Facility Related						\$ 500,000	\$ 439,000			\$ 3,189	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	\$ 439,000			\$ 3,189	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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2010 report.			\$ 15,500	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.)			\$ 15,324	2
3. Under or (over) accrual (line 2 minus line 1).			\$ (176)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 15,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 15,324	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2006	12,771	8	
	2007	13,714	9	
	2008	14,600	10	
	2009	15,204	11	
	2010	15,324	12	
An accrual estimate of \$15500 is based on a conservative income in reat estate taxes for 2012				

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Colonial Manor</u>	COUNTY	<u>Franklin</u>
---------------	-----------------------	--------	-----------------

FACILITY IDPH LICENSE NUMBER 0044610

CONTACT PERSON REGARDING THIS REPORT Greg Moore

TELEPHONE (618)596-6635 FAX #: (618)984-7734

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

(A)	(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>2-71-154-05</u>	<u>Sec TWP RNG City of Zeigler</u>	\$ <u>14,944.80</u>	\$ <u>14,944.80</u>
2. <u></u>	<u>Ex Triangular S Corner Blk 28</u>	\$ <u></u>	\$ <u></u>
3. <u>2-71-175-08</u>	<u>Sec TWP RNG Sub. Div Blk 27</u>	\$ <u>379.08</u>	\$ <u>379.08</u>
4. <u></u>	<u>Orig Plat 100 on Church & 100 on</u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u>Oak St. End Blk 28 & Pt of Blk</u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
	TOTALS	\$ <u>15,323.88</u>	\$ <u>15,323.88</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 x NO

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

C. Tax Bills

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

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

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:

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	Building Site	125,104	2000	\$ 15,000	1
2					2
3	TOTALS	125,104		\$ 15,000	3

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	49		2000	1975	\$ 1,375,228	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Sink		2000	866	58	15	58		667	9
10	Exterior Paint		2001	4,121	275	15	275		2,887	10
11	Plumbing		2001	4,471	298	15	298		3,129	11
12	Guttering		2001	6,826	455	15	455		4,777	12
13	Kitchen Wall		2002	2,840	133	15	189	56	1,796	13
14	Storage Cabinets		2005	1,400	93	15	93		605	14
15	Sidewalk		2005	1,025	68	15	68		442	15
16	Nurses Station		2005	2,861	191	15	191		1,241	16
17	Fire Damage		2007	2,087	139	15	139		625	17
18	Living Room Furniture		2008	1,407		7	201	201	737	18
19	Bath/Shower/Tub Room		2010	8,867	842	15	591	(251)	1,084	19
20	Office Sprinkler System		2011	1,984		15	33	33	33	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

*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 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	
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)		\$1,413,983	\$2,552		\$2,591	\$39	\$18,023	70

**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	\$27,999	\$916	\$4,264	\$3,348	7	\$13,335	71
72	Current Year Purchases	5,500	5,500	327	(5,173)	7	327	72
73	Fully Depreciated Assets	127,674					127,674	73
74								74
75	TOTALS	\$161,173	\$6,416	\$4,591	\$(1,825)		\$141,336	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	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	2	
	Reference	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)	\$1,610,156	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$8,968	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$7,182	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(1,786)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$179,359	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		\$	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
- NA

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: \$ 2,150Description: Copy Machine-107.00, Dishwasher-2043.00
(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:

Beginning02/01/2000

Ending02/01/2020

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2012	\$ 210,000
13.	12/31/2013	\$ 210,000
14.	12/31/2014	\$ 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

48

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

90

B. EXPENSES

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

(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.

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	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$			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 prescrpts							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.

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	\$ (50,380)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	799,628		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	777		6
7	Other Prepaid Expenses	3,566		7
8	Accounts Receivable (owners or related parties)	10,388		8
9	Other(specify): <u>A/R Misc.</u>	2,460		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 766,439	\$	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	38,758		15
16	Equipment, at Historical Cost	181,174		16
17	Accumulated Depreciation (book methods)	(200,759)		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)	\$ 19,173	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 785,612	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 65,096	\$	26
27	Officer's Accounts Payable	64,338		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	569,800		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,043		32
33	Accrued Interest Payable	15,500		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Garnishments Payable</u>	3,265		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 734,042	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 734,042	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 51,570	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 785,612	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$113,535	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$113,535	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(61,965)	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)	\$(61,965)	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)	\$51,570	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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,784,702	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,784,702	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	621	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)	\$ 8,271	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	35,650	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 35,650	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Day Train Income	310,066	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 310,066	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,138,689	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	396,576	31
32	Health Care	859,858	32
33	General Administration	337,595	33
	B. Capital Expense		
34	Ownership	252,254	34
	C. Ancillary Expense		
35	Special Cost Centers	274,380	35
36	Provider Participation Fee	79,990	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,200,653	40
41	Income before Income Taxes (line 30 minus line 40)**	(61,964)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (61,964)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? yes 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.

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	10,134	10,294	183,678	17.84	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	2,133	2,173	24,797	11.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,993	8,153	74,462	9.13	15
16	Dishwashers					16
17	Maintenance Workers	1,920	2,080	32,885	15.81	17
18	Housekeepers	2,818	2,858	23,585	8.25	18
19	Laundry	2,119	2,199	19,633	8.93	19
20	Administrator	1,920	2,080	65,769	31.62	20
21	Assistant Administrator	2,490	2,650	57,814	21.82	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,086	2,174	20,523	9.44	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)	56,546	57,562	566,079	9.83	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	92,079	94,303	\$ 1,118,025 *	\$ 11.86	34

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	131	\$ 3,279	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	2	96	10a-3	40
41	Occupational Therapy Consultant	12	1,008	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	52	3,168	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	85	3,000	10a-3	45
46	Other(specify) Dental Consultant	35	3,498	10-3	46
47	Psychologist Consultant	38	2,900	10-3	47
48	Psychiatry Consultant	22	5,500	10-3	48
49	TOTAL (lines 35 - 48)	377	\$ 22,449		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberColonial Manor# 0044610Report Period Beginning: 01/01/11Ending: 12/31/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Greg Moore	Adm./Acct.	50%	\$ 20,287
Melissa Moore	Adm./Acct.	50%	37,526
Linda Gregory	Adm./RN		65,769
Jessica Chapman	Secretary		20,524
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 144,106

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Barnett & Levine	Accounting	\$ 2,225
FMGR	Legal	3,426
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 5,651

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 25,808	
Unemployment Compensation Insurance	15,935	
FICA Taxes	85,018	
Employee Health Insurance	23,747	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
TOTAL (agree to Schedule V, line 22, col.8)		\$ 150,508

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment	957	
Health Care Worker Background Check (Indicate # of checks performed 54)	932	
Patient Background Checks	4	
Van Sticker	99	
Sam's Club Fees	70	
PO Box Fee	110	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 2,168

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

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.

\$79,990

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?

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?

NA

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 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.