

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0042168

Facility Name: Colonial Manor

Address: 620 Warrington Ave Danville 61832
Number City Zip Code

County: Vermilion

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

HFS ID Number:

Date of Initial License for Current Owners: 1977

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Craig Ater Telephone Number: (309) 823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Craig Ater
(Title) Exec VP & CFO

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) _____ Fax # () _____

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Colonial Manor

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

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	30,378	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	30,378	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	9,792	10,636	5,265	25,693	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,792	10,636	5,265	25,693	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.58%

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?

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 1977

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

K. Was the facility certified for Medicare during the reporting year? YES x NO If YES, enter number of beds certified and days of care provided 5,265

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL x 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.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	252,966	4,863		257,829		257,829	5,144	262,973			1
2	Food Purchase		177,148		177,148		177,148	38	177,186			2
3	Housekeeping	101,066	37,405		138,471		138,471		138,471			3
4	Laundry	112,672	11,887		124,559		124,559		124,559			4
5	Heat and Other Utilities			93,285	93,285		93,285	1,227	94,512			5
6	Maintenance	103,235	112,640	78,385	294,260		294,260	12,665	306,925			6
7	Other (specify):*											7
8	TOTAL General Services	569,939	343,943	171,670	1,085,552		1,085,552	19,074	1,104,626			8
	B. Health Care and Programs											
9	Medical Director			10,200	10,200		10,200	2,155	12,355			9
10	Nursing and Medical Records	1,698,958	141,105	7,242	1,847,305		1,847,305	1	1,847,306			10
10a	Therapy		488,913	631,824	1,120,737	(533,677)	587,060	(83,077)	503,983			10a
11	Activities	72,081	6,081		78,162		78,162		78,162			11
12	Social Services	49,084		3,705	52,789		52,789		52,789			12
13	CNA Training							859	859			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,820,123	636,099	652,971	3,109,193	(533,677)	2,575,516	(80,062)	2,495,454			16
	C. General Administration											
17	Administrative	82,376			82,376		82,376		82,376			17
18	Directors Fees											18
19	Professional Services			251,434	251,434		251,434	(237,809)	13,625			19
20	Dues, Fees, Subscriptions & Promotions			62,580	62,580	(45,567)	17,013	1,528	18,541			20
21	Clerical & General Office Expenses	214,755	19,674	14,726	249,155		249,155	233,655	482,810			21
22	Employee Benefits & Payroll Taxes			530,608	530,608		530,608	33,172	563,780			22
23	Inservice Training & Education			4,274	4,274		4,274	(2,275)	1,999			23
24	Travel and Seminar			3,446	3,446		3,446	(1,447)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,742	58,742		58,742	9,042	67,784			26
27	Other (specify):*			1,672	1,672		1,672		1,672			27
28	TOTAL General Administration	297,131	19,674	927,482	1,244,287	(45,567)	1,198,720	35,866	1,234,586			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,687,193	999,716	1,752,123	5,439,032	(579,244)	4,859,788	(25,122)	4,834,666			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			165,196	165,196		165,196	14,040	179,236			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			146,841	146,841		146,841	(1,013)	145,828			32
33	Real Estate Taxes			74,431	74,431		74,431	35	74,466			33
34	Rent-Facility & Grounds			7,692	7,692		7,692	(3,341)	4,351			34
35	Rent-Equipment & Vehicles			11,131	11,131		11,131	810	11,941			35
36	Other (specify):*											36
37	TOTAL Ownership			405,291	405,291		405,291	10,531	415,822			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					533,677	533,677		533,677			39
40	Barber and Beauty Shops			5,661	5,661		5,661		5,661			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					45,567	45,567		45,567			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			5,661	5,661	579,244	584,905		584,905			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,687,193	999,716	2,163,075	5,849,984		5,849,984	(14,591)	5,835,393			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	(900)			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	(1,336)			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)	(2,275)			16
17	Non-Care Related Fees	(398)			17
18	Fines and Penalties				18
19	Entertainment	(4,559)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,024)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,278)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,770)		\$	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)	8,179		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 8,179		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (14,591)		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#0042168

Report Period Beginning:01/01/12

Ending:12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(398)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(9,024)	19	22
23				23
24		0	27	24
25		(4,278)	20	25
26				26
27				27
28				28
29			33	29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(13,700)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	5,144	0	0	0	0	0	0	0	0	5,144	1
2	Food Purchase	0	0	38	0	0	0	0	0	0	0	0	38	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,227	0	0	0	0	0	0	0	0	1,227	5
6	Maintenance	0	0	12,665	0	0	0	0	0	0	0	0	12,665	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	19,074	0	0	0	0	0	0	0	0	19,074	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,155	0	0	0	0	0	0	0	0	2,155	9
10	Nursing and Medical Records	0	0	1	0	0	0	0	0	0	0	0	1	10
10a	Therapy	0	(83,077)	0	0	0	0	0	0	0	0	0	(83,077)	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	859	0	0	0	0	0	0	0	0	859	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(83,077)	3,015	0	0	0	0	0	0	0	0	(80,062)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,024)	(242,410)	13,625	0	0	0	0	0	0	0	0	(237,809)	19
20	Fees, Subscriptions & Promotions	(4,676)	0	6,204	0	0	0	0	0	0	0	0	1,528	20
21	Clerical & General Office Expenses	0	0	233,655	0	0	0	0	0	0	0	0	233,655	21
22	Employee Benefits & Payroll Taxes	0	0	33,172	0	0	0	0	0	0	0	0	33,172	22
23	Inservice Training & Education	(2,275)	0	0	0	0	0	0	0	0	0	0	(2,275)	23
24	Travel and Seminar	(4,559)	0	3,112	0	0	0	0	0	0	0	0	(1,447)	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	9,042	0	0	0	0	0	0	0	0	9,042	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,534)	(242,410)	298,810	0	0	0	0	0	0	0	0	35,866	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(20,534)	(325,487)	320,899	0	0	0	0	0	0	0	0	(25,122)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	14,040	0	0	0	0	0	0	0	14,040	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,336)	0	0	323	0	0	0	0	0	0	0	(1,013)	32
33	Real Estate Taxes	0	0	0	35	0	0	0	0	0	0	0	35	33
34	Rent-Facility & Grounds	(900)	(7,692)	0	5,251	0	0	0	0	0	0	0	(3,341)	34
35	Rent-Equipment & Vehicles	0	0	0	810	0	0	0	0	0	0	0	810	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,236)	(7,692)	0	20,459	0	0	0	0	0	0	0	10,531	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(22,770)	(333,179)	320,899	20,459	0	0	0	0	0	0	0	(14,591)	45

VII. RELATED PARTIES

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

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

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$		1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(83,077)	(83,077)	2
3	V								3
4	V	19	Adjustment for Related Organization	242,410	Heritage Operations Group, LLC	0.00%		(242,410)	4
5	V								5
6	V	34	Adjustment for Related Organization	7,692	Heritage Manor Real Estate, LLC	0.00%		(7,692)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC				10
11	V								11
12	V								12
13	V								13
14	Total			\$ 250,102			\$ (83,077)	\$ * (333,179)	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.		\$	5,144	15
16	V	2	Food Purchase					38	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,227	19
20	V	6	Maintenance					12,665	20
21	V	7	Other					0	21
22	V	9	Medical Director					2,155	22
23	V	10	Nursing & Medical Records					1	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					859	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					13,625	31
32	V	20	Fees, Subscription, Promotions					6,204	32
33	V	21	Clerical & General Office Expenses					233,655	33
34	V	22	Employee Benefits & Payroll Taxes					33,172	34
35	V	23	Inservice Training & Education					0	35
36	V	24	Travel and Seminar					3,112	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					9,042	38
39	Total			\$			\$ 0	\$ * 320,899	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.

YESNO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Enterprises, Inc.		\$	0	15
16	V	30	Depreciation					14,040	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					323	18
19	V	33	Real Estate Taxes					35	19
20	V	34	Rent-Facility & Grounds					5,251	20
21	V	35	Rent-Equipment & Vehicles					810	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	\$ * 20,459	39

* 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
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					\$ 0	0	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: 01/01/12 Ending: 12/31/12

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,735	26	\$ 169,500	\$ 168,827	83	\$ 5,144	1
2	2	Food Purchase	Beds	2,735	26	1,241	0	83	38	2
3	3	Housekeeping	Beds	2,735	26	0	0	83	0	3
4	4	Laundry	Beds	2,735	26	0	0	83	0	4
5	5	Heat & Other Utilities	Beds	2,735	26	40,426	0	83	1,227	5
6	6	Maintenance	Beds	2,735	26	417,328	78,403	83	12,665	6
7	7	Other	Beds	2,735	26	0	0	83	0	7
8	9	Medical Director	Beds	2,735	26	71,007	0	83	2,155	8
9	10	Nursing & Medical Records	Beds	2,735	26	33	70,119	83	1	9
10	11	Activities	Beds	2,735	26	0	0	83	0	10
11	12	Social Service	Beds	2,735	26	0	0	83	0	11
12	13	Nurse Aide Training	Beds	2,735	26	28,290	22,496	83	859	12
13	14	Program Transportation	Beds	2,735	26	0	0	83	0	13
14	15	Other	Beds	2,735	26	0	0	83	0	14
15	17	Administrative	Beds	2,735	26	0	0	83	0	15
16	18	Directors Fees	Beds	2,735	26	0	0	83	0	16
17	19	Professional Services	Beds	2,735	26	448,954	0	83	13,625	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	204,427	0	83	6,204	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	7,699,360	7,229,609	83	233,655	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,093,087	0	83	33,172	20
21	23	Inservice Training & Education	Beds	2,735	26	0	0	83	0	21
22	24	Travel and Seminar	Beds	2,735	26	102,532	0	83	3,112	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	83	0	23
24	26	Insurance-Prop.Liab.Malpractice	Beds	2,735	26	297,962	0	83	9,042	24
25	TOTALS					\$ 10,574,147	\$ 7,569,454		\$ 320,899	25

Facility Name & ID Number Colonial Manor # 0042168 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	2,735	26	\$	\$	83	\$	1
2	30	Depreciation	Beds	2,735	26	462,659		83	14,040	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			83		3
4	32	Interest	Beds	2,735	26	10,650		83	323	4
5	33	Real Estate Taxes	Beds	2,735	26	1,164		83	35	5
6	34	Rent-Facility & Grounds	Beds	2,735	26	173,045		83	5,251	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	26,702		83	810	7
8	36	Other	Beds	2,735	26			83		8
9	38	Medically Nec Transportation	Beds	2,735	26			83		9
10	39	Ancillary Service Centers	Beds	2,735	26			83		10
11	40	Barber and Beauty Shops	Beds	2,735	26			83		11
12	41	Coffee and Gift Shops	Beds	2,735	26			83		12
13	42	Other	Beds	2,735	26			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					\$ 674,220	\$		\$ 20,459	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	Busey Bank		x	Mortgage			\$	2,492,938			\$	123,773	1	
2	Busey Bank		x	Loan Fee Amort								2,918	2	
3													3	
4													4	
5													5	
	Working Capital													
6	Busey Bank		xx	Working Capital								20,150	6	
7													7	
8													8	
9	TOTAL Facility Related						\$	2,492,938				\$	146,841	9
	B. Non-Facility Related*													
10	Interest Income											(1,336)	10	
11													11	
12	Allocated Corporate											323	12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	(1,013)	14
15	TOTALS (line 9+line14)						\$	2,492,938				\$	145,828	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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	114,805	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.)			\$	92,311	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(22,494)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	96,925	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.			\$	74,431	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007107,7078			
		2008107,8269			
		2009112,07510			
		2010109,20611			
		201174,43112			
			FOR BHF USE ONLY		
			13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
			14	PLUS APPEAL COST FROM LINE 5 \$	14
			15	LESS REFUND FROM LINE 6 \$	15
			16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Colonial Manor

COUNTY
Vermilion

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 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	23071020150060		\$ 70,391.00	\$ 92,311.00
2.	23071020190030		\$ 198.00	\$
3.	23071020250060		\$ 18,184.00	\$
4.	23071020130060		\$ 1,857.00	\$
5.	23071080010040		\$ 1,681.00	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 92,311.00	\$ 92,311.00

B.
Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 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				\$ 111,000	1
2					2
3	TOTALS			\$ 111,000	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	83				\$ 1,709,475	\$		\$	\$	4
5					33,000					5
6										6
7										7
8										8
	Improvement Type**									
9	Architect Fees		1997		46,312					9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20	1998 Additions		1998		768,055					20
21										21
22										22
23										23
24										24
25										25
26	Addition--Materials		1999		146,931					26
27	Addition--Professional Fees		1999		3,782					27
28	WAN Building Materials		1999		4,698					28
29	Roof Repair		1999		1,783					29
30										30
31										31
32										32
33	C/O Allocation					14,040			(14,040)	33
34	Book Depreciation					124,857		124,857		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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	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	TOTAL (lines 4 thru 69)		\$ 2,826,700	\$ 138,897		\$ 124,857	\$ (14,040)	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,826,700	\$ 138,897		\$ 124,857	\$ (14,040)	\$	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 Pourch	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	\$ 138,897		\$ 124,857	\$ (14,040)	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,921,953	\$ 138,897		\$ 124,857	\$ (14,040)		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	3,897						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,494,612	\$ 138,897		\$ 124,857	\$ (14,040)		34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,494,612	\$ 138,897		\$ 124,857	\$ (14,040)		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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,494,612	\$ 138,897		\$ 124,857	\$ (14,040)		34

**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	\$40,339	\$40,339	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$515,037	\$40,339	\$40,339	\$		\$	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)	\$4,120,649	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$179,236	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$165,196	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(14,040)	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.

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? ☐ YES ☐ NO
- If NO, see instructions.

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

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. _____/2013 \$ _____
13. _____/2014 \$ _____
14. _____/2015 \$ _____

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: \$ 11,131 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* 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_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678										
	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	\$		\$ 291,978	\$		\$ 291,978	1
2	Licensed Speech and Language Development Therapist		hrs			10,263			10,263	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			276,909	7,910		284,819	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				481,003		481,003	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					52,674			52,674	13
14	TOTAL			\$		\$ 631,824	\$ 488,913		\$ 1,120,737	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 91,760	\$	1
2	Cash-Patient Deposits	2,964		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	843,470		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,760		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	845,387		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,807,341	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	112,000		13
14	Buildings, at Historical Cost	3,692,637		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	515,037		16
17	Accumulated Depreciation (book methods)	(1,769,595)		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):	11,171		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,561,250	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,368,591	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 240,263	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,964		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	228,903		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,199		31
32	Accrued Real Estate Taxes(Sch.IX-B)	96,925		32
33	Accrued Interest Payable	9,338		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Assessment Tax</u>	91,038		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 675,630	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,492,938		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)	\$ 2,492,938	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,168,568	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,200,023	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,368,591	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 967,407	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 967,407	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	232,616	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)	\$ 232,616	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)	\$ 1,200,023	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Colonial Manor# 0042168Report Period Beginning: 01/01/12Ending: 12/31/12

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,694,068	1
2	Discounts and Allowances for all Levels	(2,848,401)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,845,667	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,362,635	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,362,635	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	150	12
13	Barber and Beauty Care	4,392	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	900	16
17	Sale of Drugs	868,950	17
18	Sale of Supplies to Non-Patients		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)	\$ 874,392	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,336	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,336	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		(1,430)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (1,430)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,082,600	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,085,552	31
32	Health Care	3,109,193	32
33	General Administration	1,244,287	33
	B. Capital Expense		
34	Ownership	405,291	34
	C. Ancillary Expense		
35	Special Cost Centers	5,661	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,849,984	40
41	Income before Income Taxes (line 30 minus line 40)**	232,616	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 232,616	43

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

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

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

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

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

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	2,024	\$ 85,670	\$ 42.33	1
2	Assistant Director of Nursing	1,840	2,032	58,915	28.99	2
3	Registered Nurses	14,263	15,513	373,777	24.09	3
4	Licensed Practical Nurses	19,662	22,069	462,861	20.97	4
5	CNAs & Orderlies	61,262	66,382	717,735	10.81	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	5,301	5,544	72,081	13.00	10
11	Social Service Workers	2,736	2,906	49,084	16.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,977	22,748	252,966	11.12	15
16	Dishwashers					16
17	Maintenance Workers	6,757	7,439	103,235	13.88	17
18	Housekeepers	9,733	10,402	101,066	9.72	18
19	Laundry	11,111	11,561	112,672	9.75	19
20	Administrator	1,950	2,080	82,376	39.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,237	10,187	214,755	21.08	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)	166,749	180,887	\$ 2,687,193 *	\$ 14.86	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		10,200		36
37	Medical Records Consultant		1,710		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,980		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		3,705		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 20,595		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. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Mark Black			\$ 82,376	Workers' Compensation Insurance		\$ 62,837	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance		51,741	Advertising: Employee Recruitment	2,704	
				FICA Taxes		205,570	Health Care Worker Background Check		
				Employee Health Insurance		199,213	(Indicate # of checks performed)	3,697	
				Employee Meals			Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		0		1,321	
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits		11,247	Dues & Subscriptions	5,379	
(List each licensed administrator separately.)				Central Office Allocation		33,172	License & Fees	955	
B. Administrative - Other							Central Office Allocation	6,204	
Description			Amount				Less: Public Relations Expense	(1,321)	
			\$				Non-allowable advertising	(398)	
							Yellow page advertising (	)	
							TOTAL (agree to Sch. V, line 20, col. 8)		
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 563,780	\$ 18,541		
TOTAL (agree to Schedule V, line 17, col. 3)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount	
C. Professional Services							Out-of-State Travel	\$	
Vendor/Payee	Type		Amount						
Heritage Operations Group	Mgt		\$ 242,410						
			0						
			0				In-State Travel		
								2,688	
								33	
							Seminar Expense	725	
								(1,447)	
							Entertainment Expense (	)	
							(agree to Sch. V, line 24, col. 8)		
Legal adj to Zero			9,024				TOTAL	\$ 1,999	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL					
(If total legal fees exceed \$5,000, attach copy of invoices.)									

*** Attach copy of IMRF notifications**

****See instructions.**

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	Amount of Expense Amortized Per Year								
					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	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 years
- (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?

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.

\$ 45,567

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?

yes

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 0

Has any meal income been offset against related costs?

yes

Indicate the amount.

\$ 4,195
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100%

d. Have vehicle usage logs been maintained?

yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

yes

g. Does the facility transport residents to and from day training?

no

Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (17)

Has an audit been performed by an independent certified public accounting firm?

yes

Firm Name:

Sulaski & Webb
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out 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 Line #	Adjustment Amount			
1009	PETTY CASH	91,760				1,009		1,009	PETTY C	91,760
1010	CASH IN BANK					1,100		1,100	ACCTS R	843,470
1040	CASH IN BANK-PAYROLL					1,101		1,101	ALLOW. FOR UNCOLLECTIBI	
1100	ACCOUNTS RECEIVABLE	843,470				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	23,760
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	23,760				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	515,037
1409	LAND	112,000				1,460				(390,919)
1450	FURNITURE & EQUIPMENT	515,037				1,475		1,475	CODE AI	3,692,637
1460	ACCUM DEPR-FURN & EQU	-390,919				1,490		1,490	ACCUM I	(1,378,676)
1475	BUILDING & IMPROVEMEN	3,692,637				1,530		1,530	RESIDEN	2,964
1490	ACCUM DEPR-BUILDING	-1,378,676				1,550		1,550	LOAN FE	11,171
1530	RESIDENT FUNDS	2,964				1,551		1,551	LOAN FEES ADDED	
1550	LOAN FEES	11,171				1,850		1,850	INTERCC	845,387
1560	REAL ESTATE TAX ESCROW					2,010		2,010	ACCOUN	(240,263)
1575	REIMBURSABLE PURCHASES					2,100		2,095	BONUSES PAYABLE	
1850	INTRACOMPANY	845,387				2,100		2,100	ACCRUE	(70,732)
2010	ACCOUNTS PAYABLE	-240,263				2,100		2,100	PR CLEARING-BENEFITS	
2095	BONUSES PAYABLE					2,100		2,100	PR CLEARING-LABOR	
2100	ACCRUED PAYROLL	-70,732				2,110		2,110	ACCRUE	(158,171)
2110	ACCRUED VACATION PAY	-158,171				2,120		2,120	U.C. TAXES PAYABLE	

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(6,199)	
2125	FICA TAX PAYABLE	-6,199	-6,199	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 - CAFETERIA		
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	(9,338)	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(91,038)	
2300	ACCRUED INTEREST PAYA	-9,338		2,350	2,350 REAL ES	(96,925)	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-91,038		2,400	2,400 CURRENT PORTION OF LT DE		
2350	REAL ESTATE TAX PAYAB	-96,925		2,512	2,512 DUE TO I	(2,964)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE	(2,492,938)	
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 RETAINED	(967,407)	
2460	INCOME TAXES PAYABLE				net income	(232,616)	
2512	DUE TO RESIDENTS	-2,964					
2600	MORTGAGE PAYABLE	-2,492,938					
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>	
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	-967,407					
2970	PROFIT/LOSS FOR PERIOD	-232,616					
3007.1	PATIENT DAYS-PRIVATE	10,636					3,007

3007.2	PATIENT DAYS-IPA	9,792						3,007
3007.3	PATIENT DAYS-MEDICARE	5,265						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 &	-5,669,745	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	-15,170	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	-868,950	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-2,362,635	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	2,848,401	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	-900		6	0	6	-900	3,530
3530	13 BEAUTY SHOP	-4,392		0	0	0	0	3,560
3560	12 ACTIVITY FUND INCOME	-50		0	0	0	0	3,570
3570	12 VENDING INCOME/EXPENSE	-100		0	0	0	0	3,590
3580	12 MANAGEMENT FEES			0	0	0	0	3,595
3590	1 EQUIPMENT RENTAL	-9,153		0	0	0	0	3,600
3595	21 RESIDENT TRANSPORTATION	0		0	0	0	0	4,110
3600	21 MISC INCOME	0		0	0	0	0	4,111
4110	GENERAL & ADMINISTRATIVE WAGES	201,659	214,755	21	1	17	0	4,115
4111	ADMINISTRATOR WAGES	82,376	82,376	17	1	0	0	4,120
4115	VACATION & SICK - G&A	13,096		21	1	0	0	4,125
4120 4475	EMPLOYEE BENEFITS	12,787	530,608	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	-1,540		23	3	0	0	4,255
4220	DIRECTORS FEES	0	0	18	3	0	0	4,260
4250 4255	OFFICE SUPPLIES	19,674	19,674	21	2	0	0	4,275
4260	TELEPHONE	14,726	14,726	21	3	0	0	4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	4,274	4,274	23	3	16	-2,275 **	4,280
4280	GENERAL TRAVEL	2,688	3,446	24	3	16	0	4,281
4281	MEAL EXPENSE FOR TRAVEL	33		24	3	19	0	4,285
4285	EDUCATION & SEMINAR	725		24	3	19	-4,559 ***	4,289
4290	HELP WANTED ADVERTISING	2,704	62,580	20	3	0	0 -45,567	4,290
4291	PROMOTIONAL ADVERTISING	2,957		20	3	25	-2,957	4,291
4292	PUBLIC RELATIONS	1,321		20	3	25	-1,321	4,292
4300	LICENSES & FEES	46,522		20	3	17	0	4,300
4310	DUES & SUBSCRIPTIONS	5,379		20	3	17	-398	4,310
4320	CONTRIBUTIONS	1,602		27	3	20	0	4,320
4350	PROFESSIONAL FEES	9,024	251,434	19	3	22	-9,024	4,350
4355	MEDICAL DIRECTOR	10,200	10,200	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 CONSULT	1,710		10	3	0	0	4,364
4363	PHARMACIST FEES	4,980		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,705	3,705	12	3	0	0	4,383
4370	TV RENTAL	6,240		35	3	5	0	4,390
4380	INCOME TAXES		1,672	27	3	26	0	4,400
4383	BACKGROUND CHECKS	3,697		20	3	26	0	4,401
4400	PAYROLL TAXES	249,118		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	8,193		22	3	0	0	4,420
4410	GROUP INSURANCE	199,213		22	3	0	0	4,430
4420	LIABILITY INSURANCE	58,742	58,742	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	62,837		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	242,410		19	3	34	0 **	4,460
4460	BAD DEBTS	0		27	3	24	0	4,461
4470	LOST ITEMS-RESIDENTS	70		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	74,431	74,431	33	3	0	0	4,486
4600	LEASED EQUIPMENT	4,891	11,131	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	97,369	103,235	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	5,866		6	1	0	0	4,510
5130	ELECTRIC	45,711	93,285	5	3	0	0	4,600
5131	NATURAL GAS	18,812		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	28,762		5	3	0	0	5,130
5134	TRASH COLLECTION	37,574	78,385	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	34,453	112,640	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN	78,187		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC	40,811		6	3	0	0	5,140
5210	DIETARY WAGES	237,654	252,966	1	1	0	0	5,160
5220	DIETARY SICK & VAC	15,312		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	181,343	177,148	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	3,105	4,863	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	1,037		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	721		1	2	0	0	5,260
5295	MEAL CREDIT	-4,195		2	2	0	0	5,270
5310	LAUNDRY WAGES	108,845	112,672	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	3,827		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	4,912	11,887	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	6,975		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	98,741	101,066	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	2,325		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	20,927	37,405	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	16,478		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,698,958	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	354,764		10	1	0	0	6,020
6030	DON WAGES	85,670		10	1	0	0	6,030
6035	ADON	58,915		10	1	0	0	6,035
6040	RN SICK & VACATION	19,013		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	444,288		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	18,573		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	693,135		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	24,600		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	126,809	141,105	10	2	0	0	7,281
6295	NURSING SUPPLIES	5,590		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	8,706		10	2	0	0	7,391
6490	NURSING OTHER	552	7,242	10	3	0	0	7,393
7280	DRUG PURCHASES	309,426	488,913	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	171,577		39	2			7,540
7380	LABORATORY SERVICES	52,674	631,824	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	70,106	72,081	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	1,975		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	6,081	6,081	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	276,909		39	3	0	0 ***	7,890
7660	PT SUPPLIES	7,910		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	45,545	49,084	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	3,539		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	291,978		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	10,263		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	5,661	5,661	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	143,923	146,841	32	3	14	-1,336	
8130	DEPRECIATION	165,196	165,196	30	3	9	0	
8150	LOAN FEE AMORTIZATION	2,918		32	3	0	0	60,773
9510	INTEREST INCOME	-1,336		32	0	10	0	
9520	MISC NON-OPERATING INC	0		0	0	0	0	
9700	INCOME TAXES	1,430		0	0	0	0	
		5,850,078	5,849,984					
			-94					

GRAND TOTALS

-232,616

-22,770

(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

89

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	10,636	10,636
IPA	9,792	9,792
medicare	5,265	5,265
		25,693

IPA BEDHOLDS

0

PP BEDHOLDS

0

PP CONVERS

0

LES

3

FUND

ERIA

EBT

EBT

3,007 PATIENT 10,636

3,007 PATIENT	9,792
3,007 PATIENT	5,265
	0

3,010 BASIC CI	(5,669,745)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0

3,080 NURSING	(15,170)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(868,950)
	0

3,110 PHYSICAL	(2,362,635)
	0

3,112 PHYSICAL	0
3,113 PHYSICAL	0

3,140 LABORATORY INCOME	
	0

3,152 ST/OT TR	0
3,153 ST/OT TR	0

3,185 REHAB/ISOLATION/OTHER CHG

3,410 IPA/OTHER	0
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3,411 MEDICAL	0
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3,420 MEDICAL	2,835,174
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3,520 RENT IN	(900)
3,530 BEAUTY	(4,392)
	(50)
3,570 VENDIN	(100)
3,590 EQUIPM	(9,153)
3,595 RESIDEN	0
3,600 MISC INC	0
4,110 G&A WA	201,659
4,111 ADMINIS	82,376
4,115 G&A PTC	13,096
4,120 EMPLOY	13,224
	0
4,130 EMPLOY	0
4,135 EMPLOY	(1,540)
4,250 OFFICE S	10,359
4,255 POSTAGI	2,727
4,260 TELEPHC	14,726
4,275 TRAININ	4,274
	231
4,280 GENERA	2,688
4,281 MEAL EX	33
4,285 EDUCAT	725
4,289 MEETIN	0
4,290 HELP WA	2,704
4,291 PROMOT	2,957
4,292 PUBLIC I	1,321
4,300 LICENSE	46,522
4,310 DUES & F	5,379
4,320 CONTRIB	1,602
4,350 PROFESS	9,024
4,355 MEDICAL	10,200
	1,710
	4,980

4,364 SOCIAL S	3,705
4,370 TV RENT	6,240
4,383 BACKGR	3,697
4,390 OTHER T	1,430
4,400 PAYROL	249,118
4,401 PAYROL	8,193
4,410 GROUP I	199,213
4,420 LIABILIT	58,742
4,430 WORKM	61,266
4,435 W/C-FIRS	0
4,436 DRUG TE	1,340
4,450 MANAGI	242,410
4,460 BAD DEF	0
4,461 BAD DEF	13,227
4,470 LOST ITE	70
4,475 UNIFORM	(437)
4,486 SERVICE	17,267
4,490 MISC EX	1,692
4,496 MISC. M.	6,588
4,510 REAL ES	74,431
4,600 LEASED	4,891
5,110 MAINTEN	97,369
5,120 MAINTEN	5,866
5,130 ELECTRI	45,711
5,131 NATURA	18,812
5,133 WATER &	28,762
5,134 TRASH C	37,574
5,140 PROP/PL	34,453
5,160 GENERA	78,187
5,165 MAINTEN	23,544
5,210 DIETARY	237,654
5,220 DIETARY	15,312
5,248 FOOD PU	179,651

5,250 SUPPLIES	3,105
5,260 REPLACEMENTS	1,037
5,270 KITCHEN	721
5,295 MEAL IN	(4,195)
5,310 LAUNDRY	108,845
5,340 LAUNDRY	3,827
5,370 REPLACEMENTS	4,912
	68
5,390 SUPPLIES	6,907
5,410 HOUSEKEEPING	98,741
5,440 HOUSEKEEPING	2,325
5,480 SUPPLIES	20,927
5,490 SUPPLIES	16,478
6,020 RN WAGES	354,764
6,030 DONOR WAGES	85,670
6,035 ADONOR WAGES	58,915
6,040 RN PTO & OVERTIME	19,013
6,120 LPN WAGES	444,288
6,140 LPN PTO	18,573
6,220 AIDES WAGES	693,135
6,240 AIDES PTO	24,600
	0
	0
	0
	0
	0
	0
	0
6,270 REHAB V	0
6,275 REHAB P	0
6,290 NURSING	126,809
6,295 NURSING	5,590
6,390 REPLACEMENTS	8,706
6,490 OTHER	552

7,280 DRUG PU	309,426
7,281 DRUG PU	171,577
7,380 LABORA	21,491
7,390 X-RAY S	5,659
	25,524
7,510 ACTIVIT	70,106
7,540 ACTIVIT	1,975
7,590 ACTIVIT	6,081
7,620 PHYSICA	276,909
7,660 P.T. SUP	7,910
7,710 SOCIAL S	45,545
7,720 SOCIAL S	3,539
7,730 SOCIAL S	0
7,740 OCCUPA	291,978
	0
7,770 SPEECH '	10,263
7,820 BEAUTIC	5,661
	0
	0
8,120 INTERES	123,773
	20,150
8,130 DEPRECI	165,196
	2,918
9,510 INTERES	(1,336)
9,520 MISC NO	0
4,220	0
8,100	7,692
9,702	0
5,230	0
	<u>(232,616)</u>

Expenses Fixed Assets

FACILITY	MEDICAID NUMBER	STATE LICENSE NUMBER
Owned SNFs		
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 - Minonk, 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 Jackson, IL	20-5298969002	48918
Danville Joint Ventures, IL	37-1357323001	42168
Heritage Health - Springfield, IL	37-1359387001	41699
Cotillion Ridge, IL	37-1402726001	45138
Country Health - Springfield, IL	37-6064916001	7880
Mason City Area, IL	37-1168043001	34256
St. Clara's Medical Center, IL	37-6075710001	50724
Vonderlieth Lutheran, IL	37-0967671001	19976