

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0053413

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: 2015

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: Dave Underwood 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 01/01/16 to 12/31/16 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) David M Underwood
(Title) EVP & 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

0053413 Report Period Beginning: 01/01/16 Ending: 12/31/16

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
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	83	TOTALS	83	30,378

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	11,622	8,224	2,892	22,738
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	11,622	8,224	2,892	22,738

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.85%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO 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 2015

J. Was the facility purchased or leased after January 1, 1978? YES 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 2,892

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

MODIFIED ACCRUAL x CASH* CASH*

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

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

Facility Name & ID Number Colonial Manor # 0053413 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	262,433	12,508		274,941		274,941	4,342	279,283			1
2	Food Purchase		165,511		165,511		165,511		165,511			2
3	Housekeeping	119,801	48,125		167,926		167,926	31	167,957			3
4	Laundry	62,410	10,267		72,677		72,677		72,677			4
5	Heat and Other Utilities			85,366	85,366		85,366	1,349	86,715			5
6	Maintenance	97,106	43,486	84,659	225,251		225,251	18,166	243,417			6
7	Other (specify):*											7
8	TOTAL General Services	541,750	279,897	170,025	991,672		991,672	23,888	1,015,560			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,655,248	150,595	9,712	1,815,555		1,815,555	(20,005)	1,795,550			10
10a	Therapy		575,665	52,085	627,750	(626,328)	1,422		1,422			10a
11	Activities	68,916	1,326		70,242		70,242		70,242			11
12	Social Services	46,128		4,026	50,154		50,154		50,154			12
13	CNA Training							1,070	1,070			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,770,292	727,586	77,823	2,575,701	(626,328)	1,949,373	(18,935)	1,930,438			16
	C. General Administration											
17	Administrative	100,000			100,000		100,000		100,000			17
18	Directors Fees											18
19	Professional Services			248,590	248,590		248,590	(229,909)	18,681			19
20	Dues, Fees, Subscriptions & Promotions			195,540	195,540	(164,059)	31,481	(4,072)	27,409			20
21	Clerical & General Office Expenses	235,563	21,554	29,346	286,463		286,463	253,540	540,003			21
22	Employee Benefits & Payroll Taxes			473,435	473,435		473,435	34,217	507,652			22
23	Inservice Training & Education			7,953	7,953		7,953	1,049	9,002			23
24	Travel and Seminar			1,751	1,751		1,751	3,248	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,393	46,393		46,393	14,354	60,747			26
27	Other (specify):* Lost resident items			45,678	45,678		45,678	(43,965)	1,713			27
28	TOTAL General Administration	335,563	21,554	1,048,686	1,405,803	(164,059)	1,241,744	28,462	1,270,206			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,647,605	1,029,037	1,296,534	4,973,176	(790,387)	4,182,789	33,415	4,216,204			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							175,583	175,583			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,686	37,686		37,686	85,722	123,408			32
33	Real Estate Taxes							90,222	90,222			33
34	Rent-Facility & Grounds			372,425	372,425		372,425	(359,113)	13,312			34
35	Rent-Equipment & Vehicles			21,649	21,649		21,649	7,728	29,377			35
36	Other (specify):*											36
37	TOTAL Ownership			431,760	431,760		431,760	142	431,902			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			502,273	502,273	626,328	1,128,601	(201,826)	926,775			39
40	Barber and Beauty Shops			1,924	1,924		1,924		1,924			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					164,059	164,059		164,059			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			504,197	504,197	790,387	1,294,584	(201,826)	1,092,758			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,647,605	1,029,037	2,232,491	5,909,133		5,909,133	(168,269)	5,740,864			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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(700)			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	(691)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,168)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,661)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(43,965)			24
25	Fund Raising, Advertising and Promotional	(12,359)			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)	\$ (73,544)		\$	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)	(94,725)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (94,725)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (168,269)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(13,661)	19	22
23				23
24		(43,965)	27	24
25		(12,359)	20	25
26				26
27		0	22	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	(69,985)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Colonial Manor # 0053413 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	4,342	0	0	0	0	0	0	0	0	4,342	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	31	0	0	0	0	0	0	0	0	31	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,349	0	0	0	0	0	0	0	0	1,349	5
6	Maintenance	0	0	18,166	0	0	0	0	0	0	0	0	18,166	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	23,888	0	0	0	0	0	0	0	0	23,888	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(20,271)	266	0	0	0	0	0	0	0	0	(20,005)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,070	0	0	0	0	0	0	0	0	1,070	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	(20,271)	1,336	0	0	0	0	0	0	0	0	(18,935)	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	(13,661)	(232,894)	16,646	0	0	0	0	0	0	0	0	(229,909)	19
20	Fees, Subscriptions & Promotions	(12,359)	0	8,287	0	0	0	0	0	0	0	0	(4,072)	20
21	Clerical & General Office Expenses	0	0	253,540	0	0	0	0	0	0	0	0	253,540	21
22	Employee Benefits & Payroll Taxes	0	0	34,217	0	0	0	0	0	0	0	0	34,217	22
23	Inservice Training & Education	0	0	1,049	0	0	0	0	0	0	0	0	1,049	23
24	Travel and Seminar	(2,168)	0	5,416	0	0	0	0	0	0	0	0	3,248	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	14,354	0	0	0	0	0	0	0	0	14,354	26
27	Other (specify):*	(43,965)	0	0	0	0	0	0	0	0	0	0	(43,965)	27
28	TOTAL General Administration	(72,153)	(232,894)	333,509	0	0	0	0	0	0	0	0	28,462	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(72,153)	(253,165)	358,733	0	0	0	0	0	0	0	0	33,415	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Colonial Manor # 0053413 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	151,976	0	23,607	0	0	0	0	0	0	0	175,583	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(691)	86,160	0	253	0	0	0	0	0	0	0	85,722	32
33	Real Estate Taxes	0	90,222	0	0	0	0	0	0	0	0	0	90,222	33
34	Rent-Facility & Grounds	(700)	(363,540)	0	5,127	0	0	0	0	0	0	0	(359,113)	34
35	Rent-Equipment & Vehicles	0	0	0	7,728	0	0	0	0	0	0	0	7,728	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,391)	(35,182)	0	36,715	0	0	0	0	0	0	0	142	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	(201,826)	0	0	0	0	0	0	0	0	0	(201,826)	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	(201,826)	0	0	0	0	0	0	0	0	0	(201,826)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(73,544)	(490,173)	358,733	36,715	0	0	0	0	0	0	0	(168,269)	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	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy

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	10	Adjustment for Related Organiza	\$	GreenTree Pharmacy	0.00%	\$ (20,271)	\$ (20,271)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy	0.00%			2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	(201,826)	(201,826)	3
4	V	19	Adjustment for Related Organization	232,894	Heritage Operations Group, LLC	0.00%		(232,894)	4
5	V								5
6	V	34	Adjustment for Related Organization	363,540	Heritage Manor Real Estate, LLC	0.00%		(363,540)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		90,222	90,222	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		83,582	83,582	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		151,976	151,976	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		2,578	2,578	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 596,434			\$ 106,261	\$ * (490,173)	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 Operations Group LLC		\$	\$ 4,342	15
16	V	2	Food Purchase					0	16
17	V	3	Housekeeping					31	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,349	19
20	V	6	Maintenance					18,166	20
21	V	7	Other					0	21
22	V	9	Medical Director					0	22
23	V	10	Nursing & Medical Records					266	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,070	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					0	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					16,646	31
32	V	20	Fees, Subscription, Promotions					8,287	32
33	V	21	Clerical & General Office Expenses					253,540	33
34	V	22	Employee Benefits & Payroll Taxes					34,217	34
35	V	23	Inservice Training & Education					1,049	35
36	V	24	Travel and Seminar					5,416	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					14,354	38
39	Total			\$			\$ 0	\$ * 358,733	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Operations Group LLC		\$	0	15
16	V	30	Depreciation					23,607	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					253	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,127	20
21	V	35	Rent-Equipment & Vehicles					7,728	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	\$ * 36,715	39

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

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	
	Name	Title	Function	Ownership Interest	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	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Sole Member		100.00					\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Colonial Manor# 0053413

Report Period Beginning:

01/01/16Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Heritage Operations Group

Street Address

Box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

	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	2,571	26	\$ 134,491	\$ 133,835	83	\$ 4,342	1
2	2	Food Purchase	Beds	2,571	26	0	0	83	0	2
3	3	Housekeeping	Beds	2,571	26	965	0	83	31	3
4	4	Laundry	Beds	2,571	26	0	0	83	0	4
5	5	Heat & Other Utilities	Beds	2,571	26	41,789	0	83	1,349	5
6	6	Maintenance	Beds	2,571	26	562,719	88,582	83	18,166	6
7	7	Other	Beds	2,571	26	0	0	83	0	7
8	9	Medical Director	Beds	2,571	26	0	0	83	0	8
9	10	Nursing & Medical Records	Beds	2,571	26	8,251	9,150	83	266	9
10	11	Activities	Beds	2,571	26	0	0	83	0	10
11	12	Social Service	Beds	2,571	26	0	0	83	0	11
12	13	Nurse Aide Training	Beds	2,571	26	33,130	26,566	83	1,070	12
13	14	Program Transportation	Beds	2,571	26	0	0	83	0	13
14	15	Other	Beds	2,571	26	0	0	83	0	14
15	17	Administrative	Beds	2,571	26	0	0	83	0	15
16	18	Directors Fees	Beds	2,571	26	0	0	83	0	16
17	19	Professional Services	Beds	2,571	26	515,620	0	83	16,646	17
18	20	Fees, Subscription, Promotions	Beds	2,571	26	256,684	0	83	8,287	18
19	21	Clerical & General Office Expense	Beds	2,571	26	7,853,640	7,408,797	83	253,540	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,571	26	1,059,901	0	83	34,217	20
21	23	Inservice Training & Education	Beds	2,571	26	32,489	0	83	1,049	21
22	24	Travel and Seminar	Beds	2,571	26	167,777	0	83	5,416	22
23	25	Other Admin. Staff Transportation	Beds	2,571	26	0	0	83	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,571	26	444,625	0	83	14,354	24
25	TOTALS					\$ 11,112,081	\$ 7,666,930		\$ 358,733	25

Facility Name & ID Number Colonial Manor # 0053413 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Heritage Operations Group
Street Address Box 3188
City / State / Zip Code Bloomington, IL 61701
Phone Number ()
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,571	26	\$	\$	83	\$	1
2	30	Depreciation	Beds	2,571	26	731,247		83	23,607	2
3	31	Amortization of Pre-Op & Org	Beds	2,571	26			83		3
4	32	Interest	Beds	2,571	26	7,851		83	253	4
5	33	Real Estate Taxes	Beds	2,571	26			83		5
6	34	Rent-Facility & Grounds	Beds	2,571	26	158,824		83	5,127	6
7	35	Rent-Equipment & Vehicles	Beds	2,571	26	239,379		83	7,728	7
8	36	Other	Beds	2,571	26			83		8
9	38	Medically Nec Transportation	Beds	2,571	26			83		9
10	39	Ancillary Service Centers	Beds	2,571	26			83		10
11	40	Barber and Beauty Shops	Beds	2,571	26			83		11
12	41	Coffee and Gift Shops	Beds	2,571	26			83		12
13	42	Other	Beds	2,571	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					\$ 1,137,301	\$		\$ 36,715	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			\$					\$	83,582	1
2	Busey Bank		x	Loan Fee Amortization									2,578	2
3														3
4														4
5														5
	Working Capital													
6	Bank of America		x	Working Capital									37,686	6
7														7
8														8
9	TOTAL Facility Related						\$					\$	123,846	9
	B. Non-Facility Related*													
10	Interest Income												(691)	10
11														11
12	Allocated Corporate												253	12
13														13
14	TOTAL Non-Facility Related						\$					\$	(438)	14
15	TOTALS (line 9+line14)						\$					\$	123,408	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.				\$	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.)				\$	90,2222
3. Under or (over) accrual (line 2 minus line 1).				\$	90,2223
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	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.				\$	90,2227
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	74,431	8	
		2012	83,272	9	
		2013	84,989	10	
		2014	85,295	11	
		2015	90,222	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

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

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

FACILITY NAME Colonial Manor COUNTY Vermilion

FACILITY IDPH LICENSE NUMBER 0053413

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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:

39,770

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:

1		2		3		4	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1					\$ 112,000	1	
2						2	
3	TOTALS				\$ 112,000	3	

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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					23,607		23,607			33
34	Book Depreciation					123,628		123,628			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

Facility Name & ID Number Colonial Manor

0053413

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 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	\$ 147,235		\$ 147,235	\$	\$	70

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

Facility Name & ID Number Colonial Manor

0053413

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 2,826,700	\$ 147,235		\$ 147,235	\$	\$	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	\$ 147,235		\$ 147,235	\$	\$	34

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

Facility Name & ID Number Colonial Manor

0053413

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 2,921,953	\$ 147,235		\$ 147,235	\$	\$	1
2								2
3 Emergency Backflow	2009	2,572						3
4 Gutters	2009	8,250						4
5 Awning	2009	4,070						5
6 Aurora Pump	2009	2,969						6
7 HVAC	2009	2,729						7
8 Doors	2009	7,368						8
9 Asphalt	2009	29,063						9
10 Windows	2009	4,050						10
11								11
12 HVAC	2010	2,816						12
13 Roof	2010	91,520						13
14 Windows	2010	4,050						14
15 fire control panel	2010	3,609						15
16								16
17								17
18 Nurse Call & Tech System	2011	304,131						18
19 Purchased office building next to nursing home	2011	41,838						19
20 Roof	2011	3,977						20
21 Concrete	2011	5,090						21
22 Windows * installation	2011	30,060						22
23 Steel door	2011	8,595						23
24 sign	2011	9,067						24
25 Building repair to install washer & dryer.	2011	2,938						25
26								26
27 Lighting Upgrade	2012	2,667						27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,493,382	\$ 147,235		\$ 147,235	\$	\$	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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 3,493,382	\$ 147,235		\$ 147,235	\$	\$	1
2								2
3 Replace Fire Sprinkler	2014	3,317						3
4 Replace (10) PTAC Units	2014	4,759						4
5 Parking Lot Fill, Seal and Striping	2014	5,373						5
6 Cabling and Electrical - Point of Care Kiosks	2014	11,904						6
7 Architect Planning Fees - 2015 Remodeling Project	2014	8,454						7
8								8
9 Installation of split AC system - dining room	2015	22,128						9
10								10
11 No 2016 Improvements								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)		\$ 3,549,317	\$ 147,235		\$ 147,235	\$	\$	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	\$568,026	\$25,424	\$25,424	\$		\$	71
72	Current Year Purchases	4,137						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$572,163	\$25,424	\$25,424	\$		\$	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		2016 Dodge Grand Caravan	2016	\$40,938	\$2,924	\$2,924	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$40,938	\$2,924	\$2,924	\$		\$	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)	\$4,274,418	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$175,583	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$175,583	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Renovation of existing rooms	\$2,150,404	92
93	Addition of new therapy wing		93
94			94
95		\$2,150,404	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:None
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☐ YES☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy:☐ YES☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?☐ YES☒ NO
16. Rental Amount for movable equipment: \$21,649 Description:Televisons and office equipment
(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	None		\$	\$	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.)

	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	\$		\$ 272,657	\$		\$ 272,657	1
2	Licensed Speech and Language Development Therapist		hrs			8,219			8,219	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			221,397	1,422		222,819	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				574,243		574,243	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					52,085			52,085	13
14	TOTAL			\$		\$ 554,358	\$ 575,665		\$ 1,130,023	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	\$ 20,922	\$	1
2	Cash-Patient Deposits	4,953		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,056,456		3
4	Supply Inventory (priced at)	16,631		4
5	Short-Term Investments			5
6	Prepaid Insurance	27,125		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(456,246)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 669,841	\$	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			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 669,841	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 155,333	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,953		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	271,320		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,358		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	19,472		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 457,436	\$	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)	\$ 457,436	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 212,405	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 669,841	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,506,451	1
2	Restatements (describe):		2
3	Wrtie off of expired joint venture investment	(975,578)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 530,873	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(318,468)	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)	\$ (318,468)	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)	\$ 212,405	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Colonial Manor

0053413

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,059,433	1
2	Discounts and Allowances for all Levels	(2,505,003)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,554,430	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,896,294	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,896,294	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	980	12
13	Barber and Beauty Care	2,235	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	700	16
17	Sale of Drugs	1,140,378	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(5,043)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,139,250	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	691	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 691	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,590,665	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	991,672	31
32	Health Care	2,575,701	32
33	General Administration	1,405,803	33
	B. Capital Expense		
34	Ownership	431,760	34
	C. Ancillary Expense		
35	Special Cost Centers	504,197	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)*	\$ 5,909,133	40
41	Income before Income Taxes (line 30 minus line 40)**	(318,468)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (318,468)	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	1,421	1,496	\$ 63,873	\$ 42.70	1
2	Assistant Director of Nursing	1,790	1,884	62,533	33.19	2
3	Registered Nurses	16,806	17,691	445,616	25.19	3
4	Licensed Practical Nurses	13,889	14,620	361,065	24.70	4
5	CNAs & Orderlies	52,458	55,219	683,743	12.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,877	1,976	38,418	19.44	8
9	Activity Director					9
10	Activity Assistants	4,974	5,236	68,916	13.16	10
11	Social Service Workers	1,845	1,942	46,128	23.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,866	20,912	262,433	12.55	15
16	Dishwashers					16
17	Maintenance Workers	5,412	5,697	97,106	17.05	17
18	Housekeepers	11,226	11,817	119,801	10.14	18
19	Laundry	5,840	6,148	62,410	10.15	19
20	Administrator	1,984	2,088	100,000	47.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,436	8,880	235,563	26.53	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)	147,824	155,606	\$ 2,647,605 *	\$ 17.01	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		\$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		2,078		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,734		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		4,026		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,838		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

0053413

Report Period Beginning:01/01/16

Page 21

Ending:12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

Marsha Lock

\$ 100,000

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 100,000

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

Heritage Operations Group

Mgt services

\$ 232,893

ADP

Payroll tax processing

1,350

Tango Inc.

ACA compliance

686

Legal adj to Zero

13,661

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 248,590

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 55,443

Unemployment Compensation Insurance

51,791

FICA Taxes

202,542

Employee Health Insurance

141,547

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Other Benefits

22,112

Central Office Allocation

34,217

TOTAL (agree to Schedule V, line 22, col.8)

\$ 507,652

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

7,948

Health Care Worker Background Check (Indicate # of checks performed)

2,349

PR

1,713

Dues & Subscriptions

7,094

License & Fees

5,058

Central Office Allocation

8,287

Less: Public Relations Expense

(1,713)

Non-allowable advertising

(3,327)

Yellow page advertising (

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 27,409

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

1,751

0

Seminar Expense

0

3,248

Entertainment Expense (

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 4,999

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number <u>Colonial Manor</u>	STATE OF ILLINOIS # <u>0053413</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
 If YES, give association name and amount. HCCI

(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? 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. \$ 164,059
 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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 969

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 c. What percent of all travel expense relates to transportation of nurses and patients? 100
 d. Have vehicle usage logs been maintained? Yes
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0

(17) Has an audit been performed by an independent certified public accounting firm? Yes
 Firm Name: Sulaski & Webb

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
 Attach invoices and a summary of services for all architect and appraisal fees

Heritage Manor Danville
HFS ID# 472139886001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

		<u>Add (Subtract)</u>
<u>Reclassification of Provider Participation Fees</u>		
Provider Participation Fee - \$1.50	Line 20, Col 3	(45,567)
Provider Assesment Fee - \$6.07	Line 20, Col 3	(118,492)
		<u>(164,059)</u>
		<u>(164,059)</u>
Provider Participation Fee	Line 42	<u>164,059</u>
<u>Reclassification of Ancillary Services Cost</u>		
Cost of Drugs Purchased	Line 10(a), Col 2	(574,243)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	(52,085)
		<u>(626,328)</u>
		<u>(626,328)</u>
Ancillary Service Centers	Line 39	<u>626,328</u>