

Facility Name & ID Number Heritage Manor-Mount Sterling

0038273 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	83	Skilled (SNF)	83	30,295	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,295	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,210	5,205	2,721	19,136	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	11,210	5,205	2,721	19,136	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.17%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

none

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1985

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

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided 2,721

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Manor-Mount Sterling # 0038273 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	129,353	8,811		138,164		138,164	3,840	142,004			1
2	Food Purchase		97,715		97,715		97,715		97,715			2
3	Housekeeping	76,526	11,291		87,817		87,817	4	87,821			3
4	Laundry	23,820	9,544		33,364		33,364		33,364			4
5	Heat and Other Utilities			75,755	75,755		75,755	1,212	76,967			5
6	Maintenance	22,446	26,857	23,539	72,842		72,842	10,157	82,999			6
7	Other (specify):*											7
8	TOTAL General Services	252,145	154,218	99,294	505,657		505,657	15,213	520,870			8
	B. Health Care and Programs											
9	Medical Director			2,700	2,700		2,700		2,700			9
10	Nursing and Medical Records	740,066	24,924	7,725	772,715		772,715		772,715			10
10a	Therapy		140,439	159,910	300,349	(284,413)	15,936	124,095	140,031			10a
11	Activities	19,825	2,873		22,698		22,698		22,698			11
12	Social Services	22,539		2,291	24,830		24,830		24,830			12
13	CNA Training							1,365	1,365			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	782,430	168,236	172,626	1,123,292	(284,413)	838,879	125,460	964,339			16
	C. General Administration											
17	Administrative	52,324			52,324		52,324	58,875	111,199			17
18	Directors Fees							4,371	4,371			18
19	Professional Services			156,776	156,776		156,776	(144,632)	12,144			19
20	Dues, Fees, Subscriptions & Promotions			82,102	82,102	(47,633)	34,469	(17,687)	16,782			20
21	Clerical & General Office Expenses	51,536	7,465	13,730	72,731		72,731	121,524	194,255			21
22	Employee Benefits & Payroll Taxes			230,151	230,151		230,151	31,630	261,781			22
23	Inservice Training & Education			1,178	1,178		1,178	821	1,999			23
24	Travel and Seminar			8,824	8,824		8,824	(6,825)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			57,200	57,200		57,200	1,551	58,751			26
27	Other (specify):*			732	732		732	(732)				27
28	TOTAL General Administration	103,860	7,465	550,693	662,018	(47,633)	614,385	48,896	663,281			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,138,435	329,919	822,613	2,290,967	(332,046)	1,958,921	189,569	2,148,490			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Manor-Mount Sterling #0038273 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			79,069	79,069	79,069	10,306	89,375			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			67,824	67,824	67,824	17,906	85,730			32
33	Real Estate Taxes			35,586	35,586	35,586		35,586			33
34	Rent-Facility & Grounds						5,323	5,323			34
35	Rent-Equipment & Vehicles			3,998	3,998	3,998	964	4,962			35
36	Other (specify):*										36
37	TOTAL Ownership			186,477	186,477	186,477	34,499	220,976			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					284,413		284,413			39
40	Barber and Beauty Shops		61		61	61		61			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					47,633		47,633			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		61		61	332,046		332,107			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,138,435	329,980	1,009,090	2,477,505	2,477,505	224,068	2,701,573			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Manor-Mount Sterling

0038273

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	OHF 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	(371)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(37)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(418)	20		17
18	Fines and Penalties				18
19	Entertainment	(14,926)	24		19
20	Contributions	(732)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,785)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(20,965)	20		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	(203)	23		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (39,437)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	263,505		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 263,505		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 224,068		37

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

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

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

Heritage Manor-Mount Sterling

ID# 0038273

Report Period Beginning: 01/01/05

Ending: 12/31/05

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		(371)	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(418)	20
18			18
19			24
20		(732)	27
21			21
22		(1,785)	19
23			23
24		0	27
25		(20,965)	20
26			26
27			27
28			28
29		(203)	23
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	(24,474)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Mount Sterling

0038273

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,840	0	0	0	0	0	0	0	0	3,840	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	4	0	0	0	0	0	0	0	0	4	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,212	0	0	0	0	0	0	0	0	1,212	5
6	Maintenance	0	0	10,157	0	0	0	0	0	0	0	0	10,157	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	15,213	0	0	0	0	0	0	0	0	15,213	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	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	124,095	0	0	0	0	0	0	0	0	0	124,095	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	1,365	0	0	0	0	0	0	0	0	1,365	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	124,095	1,365	0	0	0	0	0	0	0	0	125,460	16
	C. General Administration													
17	Administrative	0	0	58,875	0	0	0	0	0	0	0	0	58,875	17
18	Directors Fees	0	0	4,371	0	0	0	0	0	0	0	0	4,371	18
19	Professional Services	(1,785)	(154,991)	12,144	0	0	0	0	0	0	0	0	(144,632)	19
20	Fees, Subscriptions & Promotions	(21,383)	0	3,696	0	0	0	0	0	0	0	0	(17,687)	20
21	Clerical & General Office Expenses	0	0	121,524	0	0	0	0	0	0	0	0	121,524	21
22	Employee Benefits & Payroll Taxes	0	0	31,630	0	0	0	0	0	0	0	0	31,630	22
23	Inservice Training & Education	(203)	0	1,024	0	0	0	0	0	0	0	0	821	23
24	Travel and Seminar	(14,926)	0	8,101	0	0	0	0	0	0	0	0	(6,825)	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	1,551	0	0	0	0	0	0	0	0	1,551	26
27	Other (specify):*	(732)	0	0	0	0	0	0	0	0	0	0	(732)	27
28	TOTAL General Administration	(39,029)	(154,991)	242,916	0	0	0	0	0	0	0	0	48,896	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(39,029)	(30,896)	259,494	0	0	0	0	0	0	0	0	189,569	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Mount Sterling # 0038273 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	10,306	0	0	0	0	0	0	0	10,306	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(37)	0	0	17,943	0	0	0	0	0	0	0	17,906	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	5,323	0	0	0	0	0	0	0	5,323	34
35	Rent-Equipment & Vehicles	(371)	0	0	1,335	0	0	0	0	0	0	0	964	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(408)	0	0	34,907	0	34,499	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)	(39,437)	(30,896)	259,494	34,907	0	224,068	45						

Facility Name & ID Number Heritage Manor-Mount Sterling

0038273

Report Period Beginning:

01/01/05

Ending:

12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V	10a Adjustment for Related Organization					
3	V						
4	V	19 Adjustment for Related Organization	154,991	Heritage Enterprises, Inc.	100.00%		(154,991)
5	V						
6	V	10a Adjustment for Related Organization	140,439	GreenTree Pharmacy	100.00%	264,534	124,095
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 295,430			\$ 264,534	\$ * (30,896)

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

Facility Name & ID Number Heritage Manor-Mount Sterling# 0038273Report Period Beginning: 01/01/05Ending: 12/31/05**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.	100.00%	\$ 3,840	\$ 3,840	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				4	4	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,212	1,212	19
20	V	6 Maintenance				10,157	10,157	20
21	V	7 Other				0		21
22	V	9 Medical Director				0		22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				0		24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				1,365	1,365	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				58,875	58,875	29
30	V	18 Directors Fees				4,371	4,371	30
31	V	19 Professional Services				12,144	12,144	31
32	V	20 Fees, Subscription, Promotions				3,696	3,696	32
33	V	21 Clerical & General Office Expenses				121,524	121,524	33
34	V	22 Employee Benefits & Payroll Taxes				31,630	31,630	34
35	V	23 Inservice Training & Education				1,024	1,024	35
36	V	24 Travel and Seminar				8,101	8,101	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				1,551	1,551	38
39	Total		\$			\$ 259,494	\$ * 259,494	39

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

Facility Name & ID Number Heritage Manor-Mount Sterling# 0038273Report Period Beginning: 01/01/05Ending: 12/31/05

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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	27	Other	\$	Heritage Enterprises, Inc.	100.00%	\$	0	15
16	V	30	Depreciation					10,306	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					17,943	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					5,323	20
21	V	35	Rent-Equipment & Vehicles					1,335	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	\$ * 34,907 39

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

Facility Name & ID Number Heritage Manor-Mount Sterling # 0038273 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Susie Jefferson	Director	Management	15.86				Salary/BOD	\$ 13,286	Ln 17 & 18	1
2	Estate of Tom Jefferson			16.21				Salary/BOD	0	Ln 17 & 18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	14,898	Ln 17 & 18	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Salary/BOD	8,871	Ln 17 & 18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	11,561	Ln 17 & 18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	5,704	Ln 17 & 18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	6,393	Ln 17 & 18	7
8	Ben Hart	Vice President	Management	3.20		40	100.00	Salary	2,533	Ln 17 & 18	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 63,246		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 Heritage Manor-Mount Sterling

0038273

Report Period Beginning:

01/01/05

Ending: 12/31/05

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 Enterprises
 Street Address 115 W. Jefferson
 City / State / Zip Code Bloomington, IL
 Phone Number ()
 Fax Number ()

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,612	25	\$ 115,289	\$ 115,276	87	\$ 3,840	1
2	2	Food Purchase	Beds	2,612	25	7	0	87	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	87	4	3
4	4	Laundry	Beds	2,612	25	0	0	87	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	87	1,212	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	87	10,157	6
7	7	Other	Beds	2,612	25	0	0	87	0	7
8	9	Medical Director	Beds	2,612	25	0	0	87	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	87	0	9
10	11	Activities	Beds	2,612	25	0	0	87	0	10
11	12	Social Service	Beds	2,612	25	0	0	87	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	87	1,365	12
13	14	Program Transportation	Beds	2,612	25	0	0	87	0	13
14	15	Other	Beds	2,612	25	0	0	87	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,691,552	87	58,875	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	87	4,371	16
17	19	Professional Services	Beds	2,612	25	364,592	0	87	12,144	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	87	3,696	18
19	21	Clerical & General Office Expense	Beds	2,612	25	3,648,522	3,385,972	87	121,524	19
20	22	Employee Benefits & Payroll Tax	Beds	2,612	25	949,625	0	87	31,630	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	87	1,024	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	87	8,101	22
23	25	Other Admin. Staff Transportatio	Beds	2,612	25	0	0	87	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	87	1,551	24
25	TOTALS					\$ 7,790,758	\$ 5,312,886		\$ 259,494	25

Facility Name & ID Number Heritage Manor-Mount Sterling

0038273

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 _____
 Street Address _____
 City / State / Zip Code _____
 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	2,612	25	\$	\$	87	\$	1
2	30	Depreciation	Beds	2,612	25	309,426		87	10,306	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25			87		3
4	32	Interest	Beds	2,612	25	538,695		87	17,943	4
5	33	Real Estate Taxes	Beds	2,612	25			87		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		87	5,323	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093		87	1,335	7
8	36	Other	Beds	2,612	25			87		8
9	38	Medically Nec Transportation	Beds	2,612	25			87		9
10	39	Ancillary Service Centers	Beds	2,612	25			87		10
11	40	Barber and Beauty Shops	Beds	2,612	25			87		11
12	41	Coffee and Gift Shops	Beds	2,612	25			87		12
13	42	Other	Beds	2,612	25			87		13
14								87		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,048,023	\$		\$ 34,907	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	LSsalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	\$	862,499	01/15/06	variable	\$ 48,637	1								
2	LSsalle National Bank		xx	Mortgage							4,591	2								
3												3								
4												4								
5												5								
Working Capital																				
6	Central Office Allocation		xx	Working Capital							14,596	6								
7	Central Office Allocation		xx	Working Capital								7								
8												8								
9	TOTAL Facility Related						\$	862,499			\$ 67,824	9								
B. Non-Facility Related*																				
10	Interest Income										(37)	10								
11												11								
12	Corporate Debt										17,943	12								
13												13								
14	TOTAL Non-Facility Related						\$				\$ 17,906	14								
15	TOTALS (line 9+line14)						\$	862,499			\$ 85,730	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 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	37,648	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.)			\$	35,724	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,924)	3																			
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	37,510	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.			\$	35,586	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:																								
2000	<u>33,513</u>	<u>8</u>	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2004	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2004	\$				13																		
14	PLUS APPEAL COST FROM LINE 5	\$				14																		
15	LESS REFUND FROM LINE 6	\$				15																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
2001	<u>30,148</u>	<u>9</u>																						
2002	<u>38,338</u>	<u>10</u>																						
2003	<u>35,458</u>	<u>11</u>																						
2004	<u>37,476</u>	<u>12</u>																						

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Mount Sterling COUNTY Brown

FACILITY IDPH LICENSE NUMBER 0038273

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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-194-001-00</u>	<u>Heritage Manor-Mount Sterling</u>	<u>\$ 35,724.00</u>	<u>\$ 35,724.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	<u>\$ 35,724.00</u>	<u>\$ 35,724.00</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Heritage Manor-Mount Sterling

0038273 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,796 B. General Construction Type: Exterior brick/wood Frame wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>8,000</u>	1
2					2
3	TOTALS			\$ 8,000	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87				\$ 914,680	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	1987 Improvements			1987	17,047						9
10	1987 Improvements			1987	73,700						10
11	1988 Improvements			1988	25,324						11
12	1989 Improvements			1989	64,856						12
13	1990 Improvements			1990	14,699						13
14	1991 Improvements			1991	18,519						14
15	1992 Improvements			1992	18,102						15
16	1993 Improvements			1993	54,992						16
17	1994 Improvements			1994	114,380						17
18	1995 Improvements			1995	22,646						18
19	Fire Alarm System			1996	27,410						19
20	Electrical Wire--Resident Rooms			1996	2,675						20
21	Drainage System			1996	5,100						21
22	Code Alert			1996	6,916						22
23	Resident Room Remodel			1996	26,925						23
24	Physical Therapy Room Remodel			1996	6,725						24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							10,306	10,306		34
35	Book Depreciation					68,562		68,562		920,209	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 Heritage Manor-Mount Sterling# 0038273

Report Period Beginning:

01/01/05

Ending:

12/31/05**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Shower/Remodel	1997	\$ 6,033	\$		\$	\$	\$	37
38	Air Conditioner	1997	1,365						38
39	Resident Room Remodel	1997	199,404						39
40									40
41	Garbage Disposal	1998	797						41
42									42
43	Gerator Repair	1999	5,712						43
44	Kitchen Air Conditioner	1999	1,450						44
45									45
46	Door Monitor System	2000	5,196						46
47	Water Heater	2000	3,995						47
48	Sink Installation & Faucet	2000	1,736						48
49									49
50	Water Main Repair	2001	2,308						50
51	Water Heater	2001	3,016						51
52									52
53	A/C Unit	2002	2,634						53
54									54
55	A/C Unit	2003	3,024						55
56	Seal Asphalt	2003	3,538						56
57	Roof	2003	9,616						57
58	Sewer Repair	2003	2,275						58
59	A/C Unit	2003	1,377						59
60	Door	2003	2,283						60
61	Water Softener	2003	1,375						61
62									62
63	Door Alarm	2004	900						63
64	Doors	2004	1,127						64
65	Kick Plates	2004	2,181						65
66	A/C Unit	2004	6,105						66
67	Water Softener	2004	4,197						67
68	Wallguard/Wallcoverings	2004	8,138						68
69	Carpet	2004	1,027						69
70	TOTAL (lines 4 thru 69)		\$ 1,695,505	\$ 68,562		\$ 78,868	\$ 10,306	\$ 920,209	70

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

Facility Name & ID Number Heritage Manor-Mount Sterling

0038273

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,695,505	\$ 68,562		\$ 78,868	\$ 10,306	\$ 920,209	1
2									2
3	Drainage System	2005	5,803						3
4	Beverage Center	2005	4,299						4
5	Gutters and downspouts	2005	2,485						5
6	Hvac	2005	4,259						6
7	A/C unit	2005	2,423						7
8	Wallguard coverings	2005	8,715						8
9	Window blinds	2005	631						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)		\$ 1,724,120	\$ 68,562		\$ 78,868	\$ 10,306	\$ 920,209	34

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

Facility Name & ID Number Heritage Manor-Mount Sterling # 0038273 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 511,008	\$ 10,507	\$ 10,507	\$		\$ 424,748	71
72	Current Year Purchases	10,497						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 521,505	\$ 10,507	\$ 10,507	\$		\$ 424,748	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	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)	\$ 2,253,625	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 79,069	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 89,375	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,306	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,344,957	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? _____

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

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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 4,962 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.

Facility Name & ID Number Heritage Manor-Mount Sterling # 0038273 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
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.

Facility Name & ID Number Heritage Manor-Mount Sterling# 0038273

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 61,226	\$		\$ 61,226	1
2	Licensed Speech and Language Development Therapist		hrs			10,530			10,530	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			68,275	0		68,275	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				264,534		264,534	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					19,879			19,879	13
14	TOTAL			\$		\$ 159,910	\$ 264,534		\$ 424,444	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Manor-Mount Sterling# 0038273Report Period Beginning: 01/01/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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	\$ 21,909	\$	1
2	Cash-Patient Deposits	3,137		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	341,607		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,622		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(36,066)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 347,209	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	125,400		13
14	Buildings, at Historical Cost	1,838,039		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	454,928		16
17	Accumulated Depreciation (book methods)	(1,344,957)		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):	383		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,073,793	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,421,002	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 35,480	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,137		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	88,310		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,383		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,510		32
33	Accrued Interest Payable	4,784		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 181,604	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	862,499		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)	\$ 862,499	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,044,103	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 376,899	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,421,002	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 278,903	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 278,903	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	97,996	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)	\$ 97,996	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)	\$ 376,899	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Mount Sterling# 0038273Report Period Beginning: 01/01/05Ending: 12/31/05**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,528,573	1
2	Discounts and Allowances for all Levels	(623,504)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,905,069	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	416,115	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 416,115	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	460	12
13	Barber and Beauty Care	398	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	252,476	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	946	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 254,280	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	37	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 37	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)	\$ 2,575,501	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	505,657	31
32	Health Care	1,123,292	32
33	General Administration	662,018	33
B. Capital Expense			
34	Ownership	186,477	34
C. Ancillary Expense			
35	Special Cost Centers	61	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)*	\$ 2,477,505	40
41	Income before Income Taxes (line 30 minus line 40)**	97,996	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 97,996	43

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

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

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

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

Facility Name & ID Number Heritage Manor-Mount Sterling

0038273

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	1,436	1,520	\$ 32,997	\$ 21.71	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	2,804	3,000	67,391	22.46	3
4	Licensed Practical Nurses	12,361	13,631	217,607	15.96	4
5	CNAs & Orderlies	36,648	39,721	402,949	10.14	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,591	1,676	19,122	11.41	8
9	Activity Director					9
10	Activity Assistants	1,658	1,922	19,825	10.31	10
11	Social Service Workers	1,921	2,112	22,539	10.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,361	14,723	129,353	8.79	15
16	Dishwashers					16
17	Maintenance Workers	1,912	2,175	22,446	10.32	17
18	Housekeepers	8,160	9,108	76,526	8.40	18
19	Laundry	3,379	3,650	23,820	6.53	19
20	Administrator	1,900	2,080	52,324	25.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,717	3,961	51,536	13.01	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)	90,848	99,279	\$ 1,138,435 *	\$ 11.47	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		2,700		36
37	Medical Records Consultant		1,200		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,256		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		2,291		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 8,447		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	160	3,999		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)	160	\$ 3,999		53

Facility Name & ID Number Heritage Manor-Mount Sterling

0038273

Report Period Beginning: 01/01/05

Ending: 12/31/05

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			
			\$ 52,324	Workers' Compensation Insurance	\$ 13,402	IDPH License Fee	\$ 1,990			
				Unemployment Compensation Insurance	20,662	Advertising: Employee Recruitment	5,140			
				FICA Taxes	87,090	Health Care Worker Background Check				
				Employee Health Insurance	101,163	(Indicate # of checks performed)	260			
				Employee Meals		Central Office Allocation	3,696			
				Illinois Municipal Retirement Fund (IMRF)*		Promotional Advertising	6,936			
				Employee Hepatitis Vaccine	0	Public Relations	14,029			
				Employee Benefits -	7,834	Dues and Subscriptions	6,114			
				Employee Benefits - central office	31,630	License and Fees	0			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 52,324	TOTAL (agree to Schedule V, line 22, col.8)			\$ 261,781	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,782
(List each licensed administrator separately.)								Less: Public Relations Expense		(14,029)
B. Administrative - Other							Non-allowable advertising		(418)	
Description			Amount				Yellow page advertising		(6,936)	
			\$							
TOTAL (agree to Schedule V, line 17, col. 3)			\$							
(Attach a copy of any management service agreement)										
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount		
			\$ 154,991			\$	Out-of-State Travel	\$		
			0							
			0							
							In-State Travel			
								4,315		
								117		
							Seminar Expense	4,392		
								(14,926)		
			0					8,101		
			1,785							
			0				Entertainment Expense	()		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 156,776	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$ 1,999
(If total legal fees exceed \$2500 attach copy of invoices.)										

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare 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? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx 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. \$ 47,633
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. \$ 2,073
- (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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, 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.

Name	Title	Function	Total Pay	Costed by Mgmt	Total # Beds	Capacity # Beds	Nursing Hours	Nursing Home	This Facility
### Susie Jefferson	Director	Management	418,245	418,245	2,612	87	3,471,750	71,391,262	
### Tom Jefferson	Secretary	Management	0	0					
### Craig Hart	Chairman	Management	469,049	469,049			21,752	447,297	14,898
### Cheryl Lowney	Executive Vice President	Management	279,290	279,290			12,952	266,338	8,871
### Steve Wannemache	President	Management	363,969	363,969			16,879	347,090	11,561
### Connie Hoselton	Sr Vice President	Management	179,584	179,584			8,328	171,256	5,704
### Craig Ater	Sr Vice President	Management	201,279	201,279			9,334	191,945	6,393
Ben Hart			79,758	79,758			3,699	76,059	2,533
13			1,991,174	1,991,174				1,898,834	63,246