

Facility Name & ID Number Heritage Manor-El Paso

0048124 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	65	Skilled (SNF)	65	23,725	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	65	TOTALS	65	23,725	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	11,698	8,708	1,207	21,613	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,698	8,708	1,207	21,613	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.10%

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 07/2006

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

YES Date 07/2006 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 1,207

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Manor-El Paso # 0048124 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	173,687	18,911		192,598		192,598	3,578	196,176		1
2	Food Purchase		140,564		140,564		140,564		140,564		2
3	Housekeeping	79,253	(8,160)		71,093		71,093	13	71,106		3
4	Laundry	62,542	7,135		69,677		69,677		69,677		4
5	Heat and Other Utilities			90,104	90,104		90,104	1,259	91,363		5
6	Maintenance	37,212	30,747	35,814	103,773		103,773	8,960	112,733		6
7	Other (specify):*										7
8	TOTAL General Services	352,694	189,197	125,918	667,809		667,809	13,810	681,619		8
	B. Health Care and Programs										
9	Medical Director			7,560	7,560		7,560	1,461	9,021		9
10	Nursing and Medical Records	964,837	68,790	160,144	1,193,771		1,193,771		1,193,771		10
10a	Therapy		119,679	204,992	324,671	(123,455)	201,216	143,597	344,813		10a
11	Activities	108,216	4,344		112,560		112,560	941	113,501		11
12	Social Services	28,536	56	1,107	29,699		29,699		29,699		12
13	CNA Training	10,739	1,018		11,757		11,757	744	12,501		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,112,328	193,887	373,803	1,680,018	(123,455)	1,556,563	146,743	1,703,306		16
	C. General Administration										
17	Administrative	64,282			64,282		64,282	45,305	109,587		17
18	Directors Fees							4,826	4,826		18
19	Professional Services			163,008	163,008		163,008	(158,092)	4,916		19
20	Dues, Fees, Subscriptions & Promotions			69,559	69,559	(35,588)	33,971	(9,253)	24,718		20
21	Clerical & General Office Expenses	91,372	19,989	8,915	120,276		120,276	101,655	221,931		21
22	Employee Benefits & Payroll Taxes			354,075	354,075		354,075	20,775	374,850		22
23	Inservice Training & Education			4,239	4,239		4,239	(2,240)	1,999		23
24	Travel and Seminar			2,982	2,982		2,982	(983)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			33,196	33,196		33,196	7,223	40,419		26
27	Other (specify):*			6,589	6,589		6,589	(6,589)			27
28	TOTAL General Administration	155,654	19,989	642,563	818,206	(35,588)	782,618	2,627	785,245		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,620,676	403,073	1,142,284	3,166,033	(159,043)	3,006,990	163,180	3,170,170		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-El Paso #0048124 Report Period Beginning: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							100,716	100,716			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,413	9,413		9,413	47,683	57,096			32
33	Real Estate Taxes							75,348	75,348			33
34	Rent-Facility & Grounds			285,430	285,430		285,430	(278,380)	7,050			34
35	Rent-Equipment & Vehicles			6,651	6,651		6,651	1,202	7,853			35
36	Other (specify):*											36
37	TOTAL Ownership			301,494	301,494		301,494	(53,431)	248,063			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					123,455	123,455		123,455			39
40	Barber and Beauty Shops			6,883	6,883		6,883		6,883			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					35,588	35,588		35,588			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			6,883	6,883	159,043	165,926		165,926			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,620,676	403,073	1,450,661	3,474,410		3,474,410	109,749	3,584,159			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		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	(2,087)	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)	(2,684)	23		16
17	Non-Care Related Fees	(312)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,488)	24		19
20	Contributions	(589)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,020)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	27		24
25	Fund Raising, Advertising and Promotional	(13,315)	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		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,495)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	145,244		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 145,244		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 109,749		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-El Paso

ID# 0048124

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	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		(2,684)	23
17		(312)	20
18			18
19			24
20		(589)	27
21			21
22		(3,020)	19
23			23
24		(6,000)	27
25		(13,315)	20
26			26
27			27
28			28
29		0	33
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	(25,920)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-El Paso

0048124

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	3,578	0	0	0	0	0	0	0	0	3,578	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	13	0	0	0	0	0	0	0	0	13	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,259	0	0	0	0	0	0	0	0	1,259	5
6	Maintenance	0	0	8,960	0	0	0	0	0	0	0	0	8,960	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	13,810	0	0	0	0	0	0	0	0	13,810	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,461	0	0	0	0	0	0	0	0	1,461	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	143,597	0	0	0	0	0	0	0	0	0	143,597	10a
11	Activities	0	0	941	0	0	0	0	0	0	0	0	941	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	744	0	0	0	0	0	0	0	0	744	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	143,597	3,146	0	0	0	0	0	0	0	0	146,743	16
	C. General Administration													
17	Administrative	0	0	45,305	0	0	0	0	0	0	0	0	45,305	17
18	Directors Fees	0	0	4,826	0	0	0	0	0	0	0	0	4,826	18
19	Professional Services	(3,020)	(159,988)	4,916	0	0	0	0	0	0	0	0	(158,092)	19
20	Fees, Subscriptions & Promotions	(13,627)	0	4,374	0	0	0	0	0	0	0	0	(9,253)	20
21	Clerical & General Office Expenses	0	0	101,655	0	0	0	0	0	0	0	0	101,655	21
22	Employee Benefits & Payroll Taxes	0	0	20,775	0	0	0	0	0	0	0	0	20,775	22
23	Inservice Training & Education	(2,684)	0	444	0	0	0	0	0	0	0	0	(2,240)	23
24	Travel and Seminar	(7,488)	0	6,505	0	0	0	0	0	0	0	0	(983)	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	7,223	0	0	0	0	0	0	0	0	7,223	26
27	Other (specify):*	(6,589)	0	0	0	0	0	0	0	0	0	0	(6,589)	27
28	TOTAL General Administration	(33,408)	(159,988)	196,023	0	0	0	0	0	0	0	0	2,627	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(33,408)	(16,391)	212,979	0	0	0	0	0	0	0	0	163,180	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-El Paso

0048124

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	93,771	0	6,945	0	0	0	0	0	0	0	100,716	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,087)	45,590	0	4,180	0	0	0	0	0	0	0	47,683	32
33	Real Estate Taxes	0	75,348	0	0	0	0	0	0	0	0	0	75,348	33
34	Rent-Facility & Grounds	0	(285,430)	0	7,050	0	0	0	0	0	0	0	(278,380)	34
35	Rent-Equipment & Vehicles	0	0	0	1,202	0	0	0	0	0	0	0	1,202	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,087)	(70,721)	0	19,377	0	(53,431)	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)	(35,495)	(87,112)	212,979	19,377	0	109,749	45						

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:
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		\$			\$	\$
2	V	10a	Adjustment for Related Organization	GreenTree Pharmacy		143,597	143,597
3	V						
4	V	19	Adjustment for Related Organization	Heritage Operations Group, LLC	0.00%		(159,988)
5	V						
6	V	34	Adjustment for Related Organization	Heritage Manor Real Estate, LLC	0.00%		(285,430)
7	V	33	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		75,348	75,348
8	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		39,728	39,728
9	V	30	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		93,771	93,771
10	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		5,862	5,862
11	V						
12	V						
13	V						
14	Total		\$ 445,418			\$ 358,306	\$ * (87,112)

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

Facility Name & ID Number Heritage Manor-El Paso# 0048124Report Period Beginning: 01/01/08Ending: 12/31/08**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.	0.00%	\$ 3,578	\$ 3,578	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				13	13	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,259	1,259	19
20	V	6 Maintenance				8,960	8,960	20
21	V	7 Other				0		21
22	V	9 Medical Director				1,461	1,461	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				941	941	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				744	744	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				45,305	45,305	29
30	V	18 Directors Fees				4,826	4,826	30
31	V	19 Professional Services				4,916	4,916	31
32	V	20 Fees, Subscription, Promotions				4,374	4,374	32
33	V	21 Clerical & General Office Expenses				101,655	101,655	33
34	V	22 Employee Benefits & Payroll Taxes				20,775	20,775	34
35	V	23 Inservice Training & Education				444	444	35
36	V	24 Travel and Seminar				6,505	6,505	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				7,223	7,223	38
39	Total		\$			\$ 212,979	\$ * 212,979	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	\$		0.00%	\$ 0	\$	15
16	V	30 Depreciation				6,945	6,945	16
17	V	31 Amortization of Pre-Op & Org				0		17
18	V	32 Interest				4,180	4,180	18
19	V	33 Real Estate Taxes				0		19
20	V	34 Rent-Facility & Grounds				7,050	7,050	20
21	V	35 Rent-Equipment & Vehicles				1,202	1,202	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		\$			\$ 19,377	\$ *	19,377 39

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

Facility Name & ID Number Heritage Manor-El Paso # 0048124 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					\$ 4,826	18/7	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	\$ 4,826		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-El Paso

0048124

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 144,981	\$ 144,706	65	\$ 3,578	1
2	2	Food Purchase	Beds	2,634	25	0	0	65	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	65	13	3
4	4	Laundry	Beds	2,634	25	0	0	65	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	65	1,259	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	65	8,960	6
7	7	Other	Beds	2,634	25	0	0	65	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	65	1,461	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	65	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	65	941	10
11	12	Social Service	Beds	2,634	25	0	0	65	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	65	744	12
13	14	Program Transportation	Beds	2,634	25	0	0	65	0	13
14	15	Other	Beds	2,634	25	0	0	65	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	65	45,305	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	65	4,826	16
17	19	Professional Services	Beds	2,634	25	199,226	0	65	4,916	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	65	4,374	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	65	101,655	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	65	20,775	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	65	444	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	65	6,505	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	65	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	65	7,223	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 212,979	25

Facility Name & ID Number Heritage Manor-El Paso

0048124

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	2,634	65	\$	\$	65	\$	1
2	30	Depreciation	Beds	2,634	65	281,453		65	6,945	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	65			65		3
4	32	Interest	Beds	2,634	65	169,367		65	4,180	4
5	33	Real Estate Taxes	Beds	2,634	65			65		5
6	34	Rent-Facility & Grounds	Beds	2,634	65	285,687		65	7,050	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	65	48,715		65	1,202	7
8	36	Other	Beds	2,634	65			65		8
9	38	Medically Nec Transportation	Beds	2,634	65			65		9
10	39	Ancillary Service Centers	Beds	2,634	65			65		10
11	40	Barber and Beauty Shops	Beds	2,634	65			65		11
12	41	Coffee and Gift Shops	Beds	2,634	65			65		12
13	42	Other	Beds	2,634	65			65		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					\$ 785,222	\$		\$ 19,377	25

Facility Name & ID Number

Heritage Manor-El Paso

0048124

Report Period Beginning:

01/01/08

Ending:

12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		xx	Mortgage			\$	763,797	03/11	variable	\$ 39,402	1
2	Bank of America		xx	Loan Fees							5,862	2
3	Bank of Springfield		xx	Van						6.0000	326	3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							9,413	6
7												7
8												8
9	TOTAL Facility Related						\$	763,797			\$ 55,003	9
	B. Non-Facility Related*											
10	Interest Income										(2,087)	10
11	Allocated Corporate										4,180	11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ 2,093	14
15	TOTALS (line 9+line14)						\$	763,797			\$ 57,096	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

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)			\$ <u>75,348</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$ <u>75,348</u>	3
4. Real Estate Tax accrual used for 2008 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.			\$ <u>75,348</u>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	<u>74,365</u>	<u>8</u>		
2004	<u>77,038</u>	<u>9</u>		
2005	<u>82,833</u>	<u>10</u>		
2006	<u>65,686</u>	<u>11</u>		
2007	<u>75,348</u>	<u>12</u>		
			FOR BHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2007 \$ 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-El Paso COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0048124

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 2007 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 2007.

(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>16-08-207-001</u>	_____	\$ <u>75,348.00</u>	\$ <u>75,348.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>75,348.00</u>	\$ <u>75,348.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Heritage Manor-El Paso

0048124 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,500 B. General Construction Type: Exterior brick Frame wood Number of Stories _____

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>22,678</u>	1
2					2
3	TOTALS			\$ <u>22,678</u>	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	65				\$ 988,669	\$		\$	\$	\$	4
5					702,618						5
6											6
7											7
8											8
Improvement Type**											
9	1987 Improvements			1987	12,921						9
10	1989 Improvements			1989	2,285						10
11	1989 Improvements			1989							11
12	1990 Improvements			1990	28,354						12
13	1991 Improvements			1991	405						13
14	1992 Improvements			1992							14
15	1993 Improvements			1993	37,061						15
16	1994 Improvements			1994	7,004						16
17	1995 Improvements			1995	3,992						17
18	A/C Frames			1996	3,695						18
19	Dinning Room A/C & Heat Unit			1996	12,007						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	C/O Allocation							6,945	6,945		34
35	Book Depreciation					69,727		69,727		949,079	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-El Paso

0048124

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	Alarm Wiring	1997	\$ 1,733	\$		\$	\$	\$	37
38	Access Doors	1997	1,075						38
39	Sinks and Faicets	1997	2,738						39
40	Walk in Cooler	1997	1,500						40
41	Motor--Boiler	1997	1,634						41
42									42
43	Kitchen Outlets and Kitchenette Addition	1998	4,389						43
44									44
45	Sprinkler Replacement	1999	4,569						45
46	Air conditioning Units	1999	6,820						46
47									47
48	Carpet Dayroom	2000	1,796						48
49									49
50	Air Handler-- Dining Room	2001	5,490						50
51	Code Alert	2001	3,833						51
52	Condensing Unit	2001	2,565						52
53	A/C Unit	2001	701						53
54	Walk-in Cooler	2001	12,696						54
55									55
56	Walk in cooler	2002	1,650						56
57	Compressor	2002	4,178						57
58	A/C Unit	2002	1,159						58
59	Exterior Door	2002	2,603						59
60	A/C Unit	2002	5,901						60
61	Heat/Cool Unit	2002	2,154						61
62	Furnace	2002	1,975						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,870,170	\$ 69,727		\$ 76,672	\$ 6,945	\$ 949,079	70

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

Facility Name & ID Number Heritage Manor-El Paso# 0048124

Report Period Beginning:

01/01/08

Ending:

12/31/08**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		\$ 1,870,170	\$ 69,727		\$ 76,672	\$ 6,945	\$ 949,079	1
2	Floor Coverings	2003	37,896						2
3	Dampers	2003	1,660						3
4	Fencing	2003	1,656						4
5	A/C unit	2003	1,738						5
6	Furnace	2003	2,450						6
7									7
8	A/C unit	2004	524						8
9	Garbage Disposal	2004	951						9
10	Water Heater	2004	3,252						10
11									11
12	Ansul System Upgrade	2005	800						12
13	A/C unit	2005	2,140						13
14	Remodel new resident room	2005	26,097						14
15	Exterior Remodel	2005	5,048						15
16	Air handler	2005	2,670						16
17	Water Service	2005	6,247						17
18									18
19	Nurse Call	2006	3,017						19
20	Sidewalk	2006	1,824						20
21	Roof repair	2006	10,751						21
22	Door Alarm	2006	13,522						22
23	A/C unit	2006	2,087						23
24	Furnace	2006	18,500						24
25	Parking Lot sealer	2006	2,353						25
26	Window Replacement	2006	60,015						26
27	Dinning room --paint and remodel	2006	8,217						27
28	Water valve	2006	2,701						28
29	Two Bed expansion -- material/labor	2006	24,784						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,111,070	\$ 69,727		\$ 76,672	\$ 6,945	\$ 949,079	34

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

Facility Name & ID Number Heritage Manor-El Paso

0048124

Report Period Beginning:

01/01/08

Ending:

12/31/08

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 12B, Carried Forward		\$ 2,111,070	\$ 69,727		\$ 76,672	\$ 6,945	\$ 949,079	1
2	Dinning room --paint and remodel	2007	14,189						2
3	Window Replacement	2007	20,175						3
4	Doors	2007	899						4
5	Flood Light	2007	837						5
6	Sprinkler heads	2007	1,314						6
7	Smoke Wall	2007	1,974						7
8	Air Handler	2007	5,690						8
9	A/C	2007	5,959						9
10	Freidrich A/C	2007	2,348						10
11	Parking Lot resurface	2007	1,200						11
12	Dishroom Flooring	2007	290						12
13									13
14	HVAC Units	2008	2,338						14
15	Nurse Call & Phone system w/ Cabling	2008	153,984						15
16	Kitchen Flooring	2008	11,403						16
17	Wireless equipment for Nurse Call	2008	9,874						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)		\$ 2,343,544	\$ 69,727		\$ 76,672	\$ 6,945	\$ 949,079	34

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

Facility Name & ID Number Heritage Manor-El Paso

0048124

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 2,343,544	\$ 69,727		\$ 76,672	\$ 6,945	\$ 949,079	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,343,544	\$ 69,727		\$ 76,672	\$ 6,945	\$ 949,079	34

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

Facility Name & ID Number Heritage Manor-El Paso # 0048124 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 523,079	\$ 24,044	\$ 24,044	\$		\$ 503,059	71
72	Current Year Purchases	36,970						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 560,049	\$ 24,044	\$ 24,044	\$		\$ 503,059	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		2009 Turtletop Van	2008	\$ 61,815	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 61,815	\$	\$	\$		\$	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)	\$ 2,988,086	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 93,771	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 100,716	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,945	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,452,138	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 6,651 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.

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		1,018		1,018
3	Classroom Wages (a)				
4	Clinical Wages (b)		10,739		10,739
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 11,757	\$	\$ 11,757
10	SUM OF line 9, col. 1 and 2 (e)	\$	11,757		

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.)

	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	\$		\$ 92,186	\$		\$ 92,186	1
2	Licensed Speech and Language Development Therapist		hrs			7,402			7,402	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			101,139	489		101,628	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				119,190		119,190	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					4,265			4,265	13
14	TOTAL			\$		\$ 204,992	\$ 119,679		\$ 324,671	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-El Paso# 0048124Report Period Beginning: 01/01/08

Ending:

12/31/08**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(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	\$ 8,372	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	496,369		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,944		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(155,846)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 367,839	\$	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)	\$ 367,839	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 119,203	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,354		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,443		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	<u>IPA Tax</u>	8,970		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 315,970	\$	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)	\$ 315,970	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 51,869	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 367,839	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 18,203	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 18,203	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	33,666	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)	\$ 33,666	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 51,869	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-El Paso

0048124

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	\$ 3,373,023	1
2	Discounts and Allowances for all Levels	(753,421)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,619,602	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	665,466	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 665,466	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	414	12
13	Barber and Beauty Care	8,352	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	212,155	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 220,921	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,087	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,087	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)	\$ 3,508,076	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	667,809	31
32	Health Care	1,680,018	32
33	General Administration	818,206	33
B. Capital Expense			
34	Ownership	301,494	34
C. Ancillary Expense			
35	Special Cost Centers	6,883	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)*	\$ 3,474,410	40
41	Income before Income Taxes (line 30 minus line 40)**	33,666	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 33,666	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-El Paso

0048124

Report Period Beginning: 01/01/08

Ending:

12/31/08

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	1,890	\$ 57,207	\$	1
2	Assistant Director of Nursing		0		2
3	Registered Nurses	6,703	196,190	37.98	3
4	Licensed Practical Nurses	7,932	202,585	24.42	4
5	CNAs & Orderlies	40,207	508,855	13.94	5
6	CNA Trainees		10,739		6
7	Licensed Therapist				7
8	Rehab/Therapy Aides		0		8
9	Activity Director				9
10	Activity Assistants	8,476	108,216	28.80	10
11	Social Service Workers	1,904	28,536	13.41	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	15,324	173,687	10.33	15
16	Dishwashers				16
17	Maintenance Workers	2,343	37,212	9.71	17
18	Housekeepers	9,127	79,253	9.96	18
19	Laundry	4,343	62,542	31.40	19
20	Administrator	1,900	64,282	30.90	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	5,298	91,372	13.19	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)	105,447	\$ 1,620,676 *	\$ 16.98	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	7,560		36
37	Medical Records Consultant	2,023		37
38	Nurse Consultant			38
39	Pharmacist Consultant	1,890		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	1,107		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 12,580		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	799 \$ 31,942		50
51	Licensed Practical Nurses	932 32,634		51
52	Certified Nurse Assistants/Aides	3,459 86,481		52
53	TOTAL (lines 50 - 52)	5,190 \$ 151,057		53

Facility Name & ID Number Heritage Manor-El Paso

0048124

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	
Diane Green	admin	0	\$ 64,282	Workers' Compensation Insurance	\$ 63,957	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	19,573	Advertising: Employee Recruitment	13,154	
				FICA Taxes	123,982	Health Care Worker Background Check		
				Employee Health Insurance	124,883	(Indicate # of checks performed)	810	
				Employee Meals		Patient Background Checks	4,374	
				Illinois Municipal Retirement Fund (IMRF)*			13,600	
					0		9,795	
TOTAL (agree to Schedule V, line 17, col. 1)					21,680	Dues & Subscriptions	4,633	
(List each licensed administrator separately.)			\$ 64,282		20,775	License & Fees	1,064	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount		Line #	Amount	Amount		
Heritage Operations Group	Mgt Fee	\$ 159,988			\$	Out-of-State Travel		
		0				\$		
		0						
		0				In-State Travel		
						493		
						0		
						Seminar Expense		
						2,489		
						(7,488)		
						Central Office		
		0				6,505		
legal to zero		3,020				Entertainment Expense		
		0				()		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 163,008	\$			\$ 1,999	

* 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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES x NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Heritage Manor ElPaso 38365 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 35,588
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. \$ 9,909
- (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? _____ If no, please explain. Not available at this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

Item	Code	Unit	Price	Quantity	Total	Remarks
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