



Facility Name & ID Number Heritage Manor-Gibson City# 0048116 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	<u>75</u>	Skilled (SNF)	<u>75</u>	<u>27,375</u>	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	<u>75</u>	TOTALS	<u>75</u>	<u>27,375</u>	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	<u>10,945</u>	<u>8,405</u>	<u>894</u>	<u>20,244</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,945</u>	<u>8,405</u>	<u>894</u>	<u>20,244</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 73.95%

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)

noneF. Does the facility maintain a daily midnight census? yesG. 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 894Medicare 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-Gibson City # 0048116 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
	<b>A. General Services</b>										
1	Dietary	186,316	6,530		192,846		192,846	4,128	196,974		1
2	Food Purchase		99,788		99,788		99,788		99,788		2
3	Housekeeping	59,441	12,462		71,903		71,903	15	71,918		3
4	Laundry	32,158	5,112		37,270		37,270		37,270		4
5	Heat and Other Utilities			71,018	71,018		71,018	1,453	72,471		5
6	Maintenance	60,140	28,381	25,569	114,090		114,090	10,339	124,429		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>338,055</b>	<b>152,273</b>	<b>96,587</b>	<b>586,915</b>		<b>586,915</b>	<b>15,935</b>	<b>602,850</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,000	13,000		13,000	1,685	14,685		9
10	Nursing and Medical Records	920,943	73,938	212,400	1,207,281		1,207,281		1,207,281		10
10a	Therapy		117,211	96,382	213,593	(130,149)	83,444	119,448	202,892		10a
11	Activities	47,234	1,995		49,229		49,229	1,085	50,314		11
12	Social Services	30,041		2,913	32,954		32,954		32,954		12
13	CNA Training		497		497		497	858	1,355		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>998,218</b>	<b>193,641</b>	<b>324,695</b>	<b>1,516,554</b>	<b>(130,149)</b>	<b>1,386,405</b>	<b>123,076</b>	<b>1,509,481</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	53,000			53,000		53,000	52,274	105,274		17
18	Directors Fees							5,568	5,568		18
19	Professional Services			158,656	158,656		158,656	(152,983)	5,673		19
20	Dues, Fees, Subscriptions & Promotions			63,576	63,576	(41,063)	22,513	(1,815)	20,698		20
21	Clerical & General Office Expenses	104,787	21,977	6,072	132,836		132,836	117,294	250,130		21
22	Employee Benefits & Payroll Taxes			299,791	299,791		299,791	23,971	323,762		22
23	Inservice Training & Education			2,989	2,989		2,989	(990)	1,999		23
24	Travel and Seminar			7,585	7,585		7,585	(5,586)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,365	47,365		47,365	8,334	55,699		26
27	Other (specify):*			6,968	6,968		6,968	(6,800)	168		27
28	<b>TOTAL General Administration</b>	<b>157,787</b>	<b>21,977</b>	<b>593,002</b>	<b>772,766</b>	<b>(41,063)</b>	<b>731,703</b>	<b>39,267</b>	<b>770,970</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,494,060</b>	<b>367,891</b>	<b>1,014,284</b>	<b>2,876,235</b>	<b>(171,212)</b>	<b>2,705,023</b>	<b>178,278</b>	<b>2,883,301</b>		<b>29</b>

\*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-Gibson City #0048116 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
	<b>D. Ownership</b>										
30	Depreciation							104,064	104,064		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			11,188	11,188		11,188	58,597	69,785		32
33	Real Estate Taxes							39,352	39,352		33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(320,365)	8,135		34
35	Rent-Equipment & Vehicles			12,257	12,257		12,257	1,387	13,644		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			351,945	351,945		351,945	(116,965)	234,980		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					130,149	130,149		130,149		39
40	Barber and Beauty Shops			4,259	4,259		4,259		4,259		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					41,063	41,063		41,063		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			4,259	4,259	171,212	175,471		175,471		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,494,060	367,891	1,370,488	3,232,439		3,232,439	61,313	3,293,752		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-Gibson City

# 0048116

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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	(2,616)	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)	(1,502)	23		16
17	Non-Care Related Fees	(748)	20		17
18	Fines and Penalties				18
19	Entertainment	(13,092)	24		19
20	Contributions	(800)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(22,189)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	27		24
25	Fund Raising, Advertising and Promotional	(6,114)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (53,061)		\$	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)	114,374		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 114,374		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 61,313		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Gibson City

ID# 0048116

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		(1,502)	23
17		(748)	20
18			18
19			24
20		(800)	27
21			21
22		(22,189)	19
23			23
24		(6,000)	27
25		(6,114)	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	<b>Total</b>	(37,353)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Gibson City

# 0048116

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	4,128	0	0	0	0	0	0	0	0	4,128	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	15	0	0	0	0	0	0	0	0	15	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,453	0	0	0	0	0	0	0	0	1,453	5
6	Maintenance	0	0	10,339	0	0	0	0	0	0	0	0	10,339	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	15,935	0	0	0	0	0	0	0	0	15,935	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	1,685	0	0	0	0	0	0	0	0	1,685	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	119,448	0	0	0	0	0	0	0	0	0	119,448	10a
11	Activities	0	0	1,085	0	0	0	0	0	0	0	0	1,085	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	858	0	0	0	0	0	0	0	0	858	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	<b>TOTAL Health Care and Programs</b>	0	119,448	3,628	0	0	0	0	0	0	0	0	123,076	16
	<b>C. General Administration</b>													
17	Administrative	0	0	52,274	0	0	0	0	0	0	0	0	52,274	17
18	Directors Fees	0	0	5,568	0	0	0	0	0	0	0	0	5,568	18
19	Professional Services	(22,189)	(136,467)	5,673	0	0	0	0	0	0	0	0	(152,983)	19
20	Fees, Subscriptions & Promotions	(6,862)	0	5,047	0	0	0	0	0	0	0	0	(1,815)	20
21	Clerical & General Office Expenses	0	0	117,294	0	0	0	0	0	0	0	0	117,294	21
22	Employee Benefits & Payroll Taxes	0	0	23,971	0	0	0	0	0	0	0	0	23,971	22
23	Inservice Training & Education	(1,502)	0	512	0	0	0	0	0	0	0	0	(990)	23
24	Travel and Seminar	(13,092)	0	7,506	0	0	0	0	0	0	0	0	(5,586)	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	8,334	0	0	0	0	0	0	0	0	8,334	26
27	Other (specify):*	(6,800)	0	0	0	0	0	0	0	0	0	0	(6,800)	27
28	<b>TOTAL General Administration</b>	(50,445)	(136,467)	226,179	0	0	0	0	0	0	0	0	39,267	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(50,445)	(17,019)	245,742	0	0	0	0	0	0	0	0	178,278	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Gibson City

# 0048116

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	96,050	0	8,014	0	0	0	0	0	0	0	104,064	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,616)	56,390	0	4,823	0	0	0	0	0	0	0	58,597	32
33	Real Estate Taxes	0	39,352	0	0	0	0	0	0	0	0	0	39,352	33
34	Rent-Facility & Grounds	0	(328,500)	0	8,135	0	0	0	0	0	0	0	(320,365)	34
35	Rent-Equipment & Vehicles	0	0	0	1,387	0	0	0	0	0	0	0	1,387	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,616)</b>	<b>(136,708)</b>	<b>0</b>	<b>22,359</b>	<b>0</b>	<b>(116,965)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(53,061)</b>	<b>(153,727)</b>	<b>245,742</b>	<b>22,359</b>	<b>0</b>	<b>61,313</b>	<b>45</b>						

Facility Name & ID Number Heritage Manor-Gibson City

# 0048116

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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		119,448	119,448
3	V						
4	V	19	Adjustment for Related Organization	Heritage Operations Group, LLC	0.00%		(136,467)
5	V						
6	V	34	Adjustment for Related Organization	Heritage Manor Real Estate, LLC	0.00%		(328,500)
7	V	33	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		39,352	39,352
8	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		49,933	49,933
9	V	30	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		96,050	96,050
10	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		6,457	6,457
11	V						
12	V						
13	V						
14	Total		\$ 464,967			\$ 311,240	\$ * (153,727)

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 Report Period Beginning: 01/01/08 Ending: 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%	\$ 4,128	\$ 4,128	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				15	15	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,453	1,453	19
20	V	6 Maintenance				10,339	10,339	20
21	V	7 Other				0		21
22	V	9 Medical Director				1,685	1,685	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,085	1,085	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				858	858	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				52,274	52,274	29
30	V	18 Directors Fees				5,568	5,568	30
31	V	19 Professional Services				5,673	5,673	31
32	V	20 Fees, Subscription, Promotions				5,047	5,047	32
33	V	21 Clerical & General Office Expenses				117,294	117,294	33
34	V	22 Employee Benefits & Payroll Taxes				23,971	23,971	34
35	V	23 Inservice Training & Education				512	512	35
36	V	24 Travel and Seminar				7,506	7,506	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				8,334	8,334	38
39	Total		\$			\$ 245,742	\$ * 245,742	39

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

Facility Name & ID Number Heritage Manor-Gibson City# 0048116Report 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	27 Other	\$		0.00%	\$ 0	\$	15
16	V	30 Depreciation				8,014		8,014 16
17	V	31 Amortization of Pre-Op & Org				0		0 17
18	V	32 Interest				4,823		4,823 18
19	V	33 Real Estate Taxes				0		0 19
20	V	34 Rent-Facility & Grounds				8,135		8,135 20
21	V	35 Rent-Equipment & Vehicles				1,387		1,387 21
22	V	36 Other				0		0 22
23	V	38 Medically Nec Transportation				0		0 23
24	V	39 Ancillary Service Centers				0		0 24
25	V	40 Barber and Beauty Shops				0		0 25
26	V	41 Coffee and Gift Shops				0		0 26
27	V	42 Other				0		0 27
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$ 22,359	\$ *	22,359 39

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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					\$ 5,568	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	\$ 5,568		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-Gibson City

# 0048116

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 144,981	\$ 144,706	75	\$ 4,128	1
2	2	Food Purchase	Beds	2,634	25	0	0	75	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	75	15	3
4	4	Laundry	Beds	2,634	25	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	75	1,453	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	75	10,339	6
7	7	Other	Beds	2,634	25	0	0	75	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	75	1,685	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	75	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	75	1,085	10
11	12	Social Service	Beds	2,634	25	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	75	858	12
13	14	Program Transportation	Beds	2,634	25	0	0	75	0	13
14	15	Other	Beds	2,634	25	0	0	75	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	75	52,274	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	75	5,568	16
17	19	Professional Services	Beds	2,634	25	199,226	0	75	5,673	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	75	5,047	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	75	117,294	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	75	23,971	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	75	512	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	75	7,506	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	75	8,334	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 245,742	25

Facility Name & ID Number Heritage Manor-Gibson City

# 0048116

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	75	\$	75	\$	1
2	30	Depreciation	Beds	2,634	75	281,453	75	8,014	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	75		75		3
4	32	Interest	Beds	2,634	75	169,367	75	4,823	4
5	33	Real Estate Taxes	Beds	2,634	75		75		5
6	34	Rent-Facility & Grounds	Beds	2,634	75	285,687	75	8,135	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	75	48,715	75	1,387	7
8	36	Other	Beds	2,634	75		75		8
9	38	Medically Nec Transportation	Beds	2,634	75		75		9
10	39	Ancillary Service Centers	Beds	2,634	75		75		10
11	40	Barber and Beauty Shops	Beds	2,634	75		75		11
12	41	Coffee and Gift Shops	Beds	2,634	75		75		12
13	42	Other	Beds	2,634	75		75		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	\$	\$ 22,359	25

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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				
		<b>A. Directly Facility Related</b>										
<b>Long-Term</b>												
1	Bank of America		xx	Mortgage			\$	763,797	03/11	variable	\$ 49,933	1
2	Bank of America		xx	Loan Fees							6,457	2
3												3
4												4
5												5
<b>Working Capital</b>												
6	Bank of America		xx	Accounts Receivable							11,188	6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	763,797			\$ 67,578	9
<b>B. Non-Facility Related*</b>												
10	Interest Income										(2,616)	10
11	Allocated Corporate										4,823	11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$				\$ 2,207	14
15	<b>TOTALS (line 9+line14)</b>						\$	763,797			\$ 69,785	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

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 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.)		\$ <b>39,352</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>39,352</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>39,352</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	<u>40,917</u>	<u>8</u>
	2004	<u>36,943</u>	<u>9</u>
	2005	<u>42,119</u>	<u>10</u>
	2006	<u>39,581</u>	<u>11</u>
	2007	<u>39,352</u>	<u>12</u>
<b>FOR BHF USE ONLY</b>			
	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.**



Facility Name & ID Number Heritage Manor-Gibson City

# 0048116 Report Period Beginning:

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12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 25,183 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>20,000</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>20,000</u>	3

Facility Name & ID Number Heritage Manor-Gibson City

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**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	75				\$ 815,350	\$		\$	\$	\$	4
5					912,769						5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	1981 Improvements			1981	41,753						9
10	1982 Improvements			1982	6,437						10
11	1983 Improvements			1983	240						11
12	1984 Improvements			1984	873						12
13	1985 Improvements			1985	7,530						13
14	1986 Improvements			1986	20,979						14
15	1987 Improvements			1987	2,222						15
16	1988 Improvements			1988	2,452						16
17	1989 Improvements			1989	28,639						17
18	1990 Improvements			1990	99,326						18
19	1991 Improvements			1991	36,637						19
20	1993 Improvements			1993	40,838						20
21	1994 Improvements			1994	66,399						21
22	1995 Improvements			1995	1,060						22
23	WINDOW REPLACEMENTS			1996	25,247						23
24	WATER HEATER			1996	1,639						24
25	RESIDENT ROOM REMODEL/PAINTING			1996	7,584						25
26	Parking Lot			1998	12,299						26
27											27
28	Smoke Dampers			1999	5,256						28
29	Water Heater			1999	1,971						29
30	Garbage Disposal			1999	1,693						30
31	Heat/Cool compressor			1999	3,277						31
32	Smoke Dampers			2000	1,295						32
33											33
34	C/O Allocation							8,014	8,014		34
35	Book Depreciation					71,388		71,388		1,029,671	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 &amp; ID Number Heritage Manor-Gibson City

# 0048116

Report Period Beginning:

01/01/08

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**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	Temperature Control Unit	2001	\$ 1,700	\$		\$	\$	\$	37
38	AC Replacement	2001	4,400						38
39	Smoke Detection System								39
40									40
41	Smoke Detection System	2002	1,775						41
42	Landscaping	2002	1,425						42
43	Fire Supression	2002	4,458						43
44	Water Heater	2002	2,396						44
45	Keypad Perimeter	2002	941						45
46	Sealcoat Parking Lot	2002	1,371						46
47	Garbage Disposal	2002	1,520						47
48	Hot Water Tank	2002	3,168						48
49	Rehab Hallway--Wallpaper/Paint	2002	14,442						49
50									50
51	Exterior Doors	2003	2,195						51
52	Roof Replacement	2003	28,555						52
53	Security Door	2003	1,116						53
54	Water Heater	2003	1,999						54
55	Water Tank	2003	1,836						55
56									56
57	HVAC unit	2004	5,247						57
58	Grease Trap	2004	1,903						58
59	Quarry Tile	2004	3,165						59
60	Parking Lot Sealcoat	2004	1,579						60
61	HVAC unit	2004	1,000						61
62	Sprinkler Leak	2004	1,854						62
63	Hot Water Boiler	2004	2,133						63
64	Corridor Remodel Material and Labor	2004	20,242						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,254,185	\$ 71,388		\$ 79,402	\$ 8,014	\$ 1,029,671	70

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

Facility Name &amp; ID Number Heritage Manor-Gibson City

# 0048116

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**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,254,185	\$ 71,388		\$ 79,402	\$ 8,014	\$ 1,029,671	1
2	Oxygen Room	2005	2,005						2
3	Heat/Cool Unit	2005	17,228						3
4									4
5	Heat/Cool Units	2006	25,182						5
6	Door	2006	2,887						6
7	Heater	2006	1,078						7
8	Sidewalk	2006	3,500						8
9	Boiler	2006	1,427						9
10	Remodel TLC Unit --carpet, paint,	2006	27,516						10
11	Parking Lot sealer	2006	1,699						11
12	Drapes	2006	1,172						12
13	adjustments	2006	(7,711)						13
14	dishwasher motor	2007							14
15	Remodel TLC Unit --carpet, paint,	2007	2,996						15
16	Water Heater	2007	2,907						16
17	Grease Trap	2007							17
18	Water Softener	2007	12,285						18
19									19
20	Emergency Alarms	2008	36,893						20
21									21
22	Water Heater	2008	4,982						22
23	Exterior Painting	2008	9,720						23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,399,951	\$ 71,388		\$ 79,402	\$ 8,014	\$ 1,029,671	34

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

Facility Name & ID Number Heritage Manor-Gibson City

# 0048116

Report Period Beginning:

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Ending:

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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		\$ 2,399,951	\$ 71,388		\$ 79,402	\$ 8,014	\$ 1,029,671	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)	\$ 2,399,951	\$ 71,388		\$ 79,402	\$ 8,014	\$ 1,029,671	34

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

Facility Name & ID Number Heritage Manor-Gibson City

# 0048116

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 12C, Carried Forward	\$ 2,399,951	\$ 71,388		\$ 79,402	\$ 8,014	\$ 1,029,671		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)	\$ 2,399,951	\$ 71,388		\$ 79,402	\$ 8,014	\$ 1,029,671		34

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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	\$ 436,445	\$ 24,662	\$ 24,662	\$		\$ 409,441	71
72	Current Year Purchases	18,634						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 455,079	\$ 24,662	\$ 24,662	\$		\$ 409,441	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)	\$ 2,875,030	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,050	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 104,064	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,014	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,439,112	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	<b>TOTAL</b>				\$ _____			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: \$ 12,257 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	<b>TOTAL</b>		\$ _____	\$ _____	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-Gibson City # 0048116 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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		497		497
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	\$	\$ 497	\$	\$ 497
10	SUM OF line 9, col. 1 and 2 (e)	\$	497		

**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)	
<b>TOTAL TRAINED</b>	

- (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-Gibson City# 0048116 Report Period Beginning:01/01/08 Ending:12/31/08

## 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	\$		\$ 43,807	\$		\$ 43,807	1
2	Licensed Speech and Language Development Therapist		hrs			809			809	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			38,821	7		38,828	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				117,204		117,204	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					12,945			12,945	13
14	TOTAL			\$		\$ 96,382	\$ 117,211		\$ 213,593	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-Gibson City# 0048116Report 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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,058	\$	1
2	Cash-Patient Deposits	5,464		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	401,041		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,716		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(944,871)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (522,592)	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (522,592)	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 110,179	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,464		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	155,459		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,936		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>IPA Tax</u>	10,350		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 283,388	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 283,388	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (805,980)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (522,592)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (421,451)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (421,451)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(384,529)	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)	\$ (384,529)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (805,980)	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Gibson City# 0048116Report Period Beginning: 01/01/08Ending: 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,899,753	1
2	Discounts and Allowances for all Levels	(546,229)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,353,524	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	295,322	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 295,322	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	(60)	11
12	Gift and Coffee Shop	7,561	12
13	Barber and Beauty Care	6,307	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	202,136	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 215,948	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	(19,500)	24
25	Interest and Other Investment Income***	2,616	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ (16,884)	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,847,910	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	586,915	31
32	Health Care	1,516,554	32
33	General Administration	772,766	33
<b>B. Capital Expense</b>			
34	Ownership	351,945	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	4,259	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,232,439	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(384,529)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (384,529)	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-Gibson City

# 0048116

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	1,975	\$ 59,793	\$	1
2	Assistant Director of Nursing		0		2
3	Registered Nurses	4,871	143,652	27.81	3
4	Licensed Practical Nurses	7,886	211,590	25.51	4
5	CNAs & Orderlies	34,778	440,525	12.07	5
6	CNA Trainees		0		6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	3,677	65,383	15.45	8
9	Activity Director				9
10	Activity Assistants	3,602	47,234	12.57	10
11	Social Service Workers	1,896	30,041	14.12	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	15,311	186,316	11.08	15
16	Dishwashers				16
17	Maintenance Workers	3,571	60,140	15.69	17
18	Housekeepers	7,412	59,441	7.47	18
19	Laundry	1,783	32,158	16.14	19
20	Administrator		53,000		20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	6,190	104,787	15.12	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)	92,952	\$ 1,494,060 *	\$ 15.31	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	13,000		36
37	Medical Records Consultant	2,280		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,250		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	2,913		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 20,443		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 61,108		50
51	Licensed Practical Nurses	67,558		51
52	Certified Nurse Assistants/Aides	78,931		52
53	TOTAL (lines 50 - 52)	\$ 207,597		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Karen Christenson	admin	0	\$ 53,000	Workers' Compensation Insurance	\$ 38,976	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	18,589	Advertising: Employee Recruitment	6,480	
				FICA Taxes	114,296	Health Care Worker Background Check		
				Employee Health Insurance	112,969	(Indicate # of checks performed)	860	
				Employee Meals		Patient Background Checks	5,047	
				Illinois Municipal Retirement Fund (IMRF)*			13,600	
					0		4,138	
TOTAL (agree to Schedule V, line 17, col. 1)					14,961	Dues & Subscriptions	5,294	
(List each licensed administrator separately.)			\$ 53,000		23,971	License & Fees	3,765	
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	\$ 136,467			\$	Out-of-State Travel		
		0				\$		
		0						
		0				In-State Travel		
						3,771		
						79		
						Seminar Expense		
						3,735		
						(13,092)		
		0				Central Office		
Adjusted to Zero		22,189				7,506		
		0				Entertainment Expense		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 158,656				\$ 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 Gibson City 38315 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 41,063  
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.

Account	CC	Code	Desc	Rate	Plan	Rate	Plan
1000			1000				
1001			1001				
1002			1002				
1003			1003				
1004			1004				
1005			1005				
1006			1006				
1007			1007				
1008			1008				
1009			1009				
1010			1010				
1011			1011				
1012			1012				
1013			1013				
1014			1014				
1015			1015				
1016			1016				
1017			1017				
1018			1018				
1019			1019				
1020			1020				
1021			1021				
1022			1022				
1023			1023				
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