



Facility Name & ID Number Heritage Manor-Mendota# 0048108 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>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</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>99</u>	TOTALS	<u>99</u>	<u>36,135</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>15,224</u>	<u>9,516</u>	<u>3,108</u>	<u>27,848</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>15,224</u>	<u>9,516</u>	<u>3,108</u>	<u>27,848</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.07%

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? yes

G. Do pages 3 &amp; 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 3,108Medicare 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-Mendota # 0048108 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	214,630	20,112		234,742		234,742	5,449	240,191			1
2	Food Purchase		147,793		147,793		147,793		147,793			2
3	Housekeeping	70,723	20,426		91,149		91,149	20	91,169			3
4	Laundry	60,469	15,275		75,744		75,744		75,744			4
5	Heat and Other Utilities			105,963	105,963		105,963	1,918	107,881			5
6	Maintenance	54,977	33,668	41,804	130,449		130,449	13,647	144,096			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>400,799</b>	<b>237,274</b>	<b>147,767</b>	<b>785,840</b>		<b>785,840</b>	<b>21,034</b>	<b>806,874</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			8,400	8,400		8,400	2,225	10,625			9
10	Nursing and Medical Records	1,432,276	108,022	228,658	1,768,956		1,768,956		1,768,956			10
10a	Therapy		214,790	307,081	521,871	(243,841)	278,030	136,901	414,931			10a
11	Activities	70,837	4,934		75,771		75,771	1,433	77,204			11
12	Social Services	32,369	39	1,548	33,956		33,956		33,956			12
13	CNA Training							1,133	1,133			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,535,482</b>	<b>327,785</b>	<b>545,687</b>	<b>2,408,954</b>	<b>(243,841)</b>	<b>2,165,113</b>	<b>141,692</b>	<b>2,306,805</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	84,523			84,523		84,523	69,002	153,525			17
18	Directors Fees							7,350	7,350			18
19	Professional Services			214,863	214,863		214,863	(207,375)	7,488			19
20	Dues, Fees, Subscriptions & Promotions			85,780	85,780	(54,203)	31,577	(12,863)	18,714			20
21	Clerical & General Office Expenses	143,728	22,615	10,203	176,546		176,546	154,828	331,374			21
22	Employee Benefits & Payroll Taxes			436,493	436,493		436,493	31,641	468,134			22
23	Inservice Training & Education			2,084	2,084		2,084	(85)	1,999			23
24	Travel and Seminar			5,280	5,280		5,280	(3,281)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,419	43,419		43,419	11,001	54,420			26
27	Other (specify):*			70	70		70	(70)				27
28	<b>TOTAL General Administration</b>	<b>228,251</b>	<b>22,615</b>	<b>798,192</b>	<b>1,049,058</b>	<b>(54,203)</b>	<b>994,855</b>	<b>50,148</b>	<b>1,045,003</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,164,532</b>	<b>587,674</b>	<b>1,491,646</b>	<b>4,243,852</b>	<b>(298,044)</b>	<b>3,945,808</b>	<b>212,874</b>	<b>4,158,682</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-Mendota #0048108 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							156,864	156,864			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,807	14,807		14,807	124,115	138,922			32
33	Real Estate Taxes							42,424	42,424			33
34	Rent-Facility & Grounds			433,620	433,620		433,620	(423,528)	10,092			34
35	Rent-Equipment & Vehicles			1,064	1,064		1,064	1,831	2,895			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			449,491	449,491		449,491	(98,294)	351,197			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					243,841	243,841		243,841			39
40	Barber and Beauty Shops		265	7,519	7,784		7,784		7,784			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					54,203	54,203		54,203			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		265	7,519	7,784	298,044	305,828		305,828			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,164,532	587,939	1,948,656	4,701,127		4,701,127	114,580	4,815,707			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-Mendota

# 0048108

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	(646)	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	(4,401)	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)	(761)	23		16
17	Non-Care Related Fees	(895)	20		17
18	Fines and Penalties				18
19	Entertainment	(13,188)	24		19
20	Contributions	(70)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,669)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(18,630)	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>	\$ (44,260)		\$	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)	158,840		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 158,840		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 114,580		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.

		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-Mendota

ID# 0048108

Report Period Beginning: 01/01/08

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		(646)	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16		(761)	23
17		(895)	20
18			18
19			24
20		(70)	27
21			21
22		(5,669)	19
23			23
24		0	27
25		(18,630)	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>	(26,671)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Mendota

# 0048108

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	5,449	0	0	0	0	0	0	0	0	5,449	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	20	0	0	0	0	0	0	0	0	20	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,918	0	0	0	0	0	0	0	0	1,918	5
6	Maintenance	0	0	13,647	0	0	0	0	0	0	0	0	13,647	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	21,034	0	0	0	0	0	0	0	0	21,034	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	2,225	0	0	0	0	0	0	0	0	2,225	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	136,901	0	0	0	0	0	0	0	0	0	136,901	10a
11	Activities	0	0	1,433	0	0	0	0	0	0	0	0	1,433	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,133	0	0	0	0	0	0	0	0	1,133	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	136,901	4,791	0	0	0	0	0	0	0	0	141,692	16
	<b>C. General Administration</b>													
17	Administrative	0	0	69,002	0	0	0	0	0	0	0	0	69,002	17
18	Directors Fees	0	0	7,350	0	0	0	0	0	0	0	0	7,350	18
19	Professional Services	(5,669)	(209,194)	7,488	0	0	0	0	0	0	0	0	(207,375)	19
20	Fees, Subscriptions & Promotions	(19,525)	0	6,662	0	0	0	0	0	0	0	0	(12,863)	20
21	Clerical & General Office Expenses	0	0	154,828	0	0	0	0	0	0	0	0	154,828	21
22	Employee Benefits & Payroll Taxes	0	0	31,641	0	0	0	0	0	0	0	0	31,641	22
23	Inservice Training & Education	(761)	0	676	0	0	0	0	0	0	0	0	(85)	23
24	Travel and Seminar	(13,188)	0	9,907	0	0	0	0	0	0	0	0	(3,281)	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	11,001	0	0	0	0	0	0	0	0	11,001	26
27	Other (specify):*	(70)	0	0	0	0	0	0	0	0	0	0	(70)	27
28	<b>TOTAL General Administration</b>	(39,213)	(209,194)	298,555	0	0	0	0	0	0	0	0	50,148	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(39,213)	(72,293)	324,380	0	0	0	0	0	0	0	0	212,874	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Mendota

# 0048108

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	146,285	0	10,579	0	0	0	0	0	0	0	156,864	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,401)	122,150	0	6,366	0	0	0	0	0	0	0	124,115	32
33	Real Estate Taxes	0	42,424	0	0	0	0	0	0	0	0	0	42,424	33
34	Rent-Facility & Grounds	(646)	(433,620)	0	10,738	0	0	0	0	0	0	0	(423,528)	34
35	Rent-Equipment & Vehicles	0	0	0	1,831	0	0	0	0	0	0	0	1,831	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(5,047)</b>	<b>(122,761)</b>	<b>0</b>	<b>29,514</b>	<b>0</b>	<b>(98,294)</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>(44,260)</b>	<b>(195,054)</b>	<b>324,380</b>	<b>29,514</b>	<b>0</b>	<b>114,580</b>	<b>45</b>						

Facility Name & ID Number Heritage Manor-Mendota

# 0048108

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		136,901	136,901
3	V						
4	V	19	Adjustment for Related Organization	Heritage Operations Group, LLC	0.00%		(209,194)
5	V						
6	V	34	Adjustment for Related Organization	Heritage Manor Real Estate, LLC	0.00%		(433,620)
7	V	33	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		42,424	42,424
8	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		115,435	115,435
9	V	30	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		146,285	146,285
10	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		6,715	6,715
11	V						
12	V						
13	V						
14	Total		\$ 642,814			\$ 447,760	\$ * (195,054)

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

Facility Name & ID Number Heritage Manor-Mendota# 0048108Report 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%	\$ 5,449	\$ 5,449	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				20	20	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,918	1,918	19
20	V	6 Maintenance				13,647	13,647	20
21	V	7 Other				0		21
22	V	9 Medical Director				2,225	2,225	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,433	1,433	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				1,133	1,133	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				69,002	69,002	29
30	V	18 Directors Fees				7,350	7,350	30
31	V	19 Professional Services				7,488	7,488	31
32	V	20 Fees, Subscription, Promotions				6,662	6,662	32
33	V	21 Clerical & General Office Expenses				154,828	154,828	33
34	V	22 Employee Benefits & Payroll Taxes				31,641	31,641	34
35	V	23 Inservice Training & Education				676	676	35
36	V	24 Travel and Seminar				9,907	9,907	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				11,001	11,001	38
39	Total		\$			\$ 324,380	\$ * 324,380	39

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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	27 Other	\$		0.00%	\$ 0	\$	15
16	V	30 Depreciation				10,579	10,579	16
17	V	31 Amortization of Pre-Op & Org				0		17
18	V	32 Interest				6,366	6,366	18
19	V	33 Real Estate Taxes				0		19
20	V	34 Rent-Facility & Grounds				10,738	10,738	20
21	V	35 Rent-Equipment & Vehicles				1,831	1,831	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		\$			\$ 29,514	\$ *	29,514 39

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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					\$ 7,350	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	\$ 7,350		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-Mendota

# 0048108

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	99	\$ 5,449	1
2	2	Food Purchase	Beds	2,634	25	0	0	99	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	99	20	3
4	4	Laundry	Beds	2,634	25	0	0	99	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	99	1,918	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	99	13,647	6
7	7	Other	Beds	2,634	25	0	0	99	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	99	2,225	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	99	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	99	1,433	10
11	12	Social Service	Beds	2,634	25	0	0	99	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	99	1,133	12
13	14	Program Transportation	Beds	2,634	25	0	0	99	0	13
14	15	Other	Beds	2,634	25	0	0	99	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	99	69,002	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	99	7,350	16
17	19	Professional Services	Beds	2,634	25	199,226	0	99	7,488	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	99	6,662	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	99	154,828	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	99	31,641	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	99	676	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	99	9,907	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	99	11,001	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 324,380	25

Facility Name & ID Number Heritage Manor-Mendota

# 0048108

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	99	\$	\$	99	\$	1
2	30	Depreciation	Beds	2,634	99	281,453		99	10,579	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	99			99		3
4	32	Interest	Beds	2,634	99	169,367		99	6,366	4
5	33	Real Estate Taxes	Beds	2,634	99			99		5
6	34	Rent-Facility & Grounds	Beds	2,634	99	285,687		99	10,738	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	99	48,715		99	1,831	7
8	36	Other	Beds	2,634	99			99		8
9	38	Medically Nec Transportation	Beds	2,634	99			99		9
10	39	Ancillary Service Centers	Beds	2,634	99			99		10
11	40	Barber and Beauty Shops	Beds	2,634	99			99		11
12	41	Coffee and Gift Shops	Beds	2,634	99			99		12
13	42	Other	Beds	2,634	99			99		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	\$		\$ 29,514	25

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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			\$	\$ 1,699,037	03/11	variable	\$ 112,681	1
2	Bank of America		xx	Loan Fees							6,715	2
3	Alpha Bank		xx	Van				33,023		5.5000	2,754	3
4												4
5												5
<b>Working Capital</b>												
6	Bank of America		xx	Accounts Receivable							14,807	6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$ 1,732,060			\$ 136,957	9
<b>B. Non-Facility Related*</b>												
10	Interest Income										(4,401)	10
11	Allocated Corporate										6,366	11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 1,965	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 1,732,060			\$ 138,922	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.)		\$ <u>42,424</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <u>42,424</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. <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.		\$ <u>42,424</u>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	<u>24,907</u>	<u>8</u>
	2004	<u>26,183</u>	<u>9</u>
	2005	<u>32,066</u>	<u>10</u>
	2006	<u>73,732</u>	<u>11</u>
	2007	<u>42,424</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-Mendota

# 0048108 Report Period Beginning:

01/01/08 Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 20,555 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>26,150</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>26,150</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	99				\$ 697,500	\$		\$	\$	\$	4
5					408,657						5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	1980 Improvements			1980	8,150						9
10	1981 Improvements			1981	20,492						10
11	1982 Improvements			1982	9,185						11
12	1983 Improvements			1983	5,682						12
13	1984 Improvements			1984	11,488						13
14	1985 Improvements			1985	7,710						14
15	1986 Improvements			1986	2,255						15
16	1987 Improvements			1987	9,037						16
17	1988 Improvements			1988	21,297						17
18	1989 Improvements			1989	4,653						18
19	1990 Improvements			1990	36,595						19
20	1991 Improvements			1991							20
21	1992 Improvements			1992	10,646						21
22	1993 Improvements			1993	62,261						22
23	1994 Improvements			1994	10,869						23
24	1995 Improvements			1995	18,523						24
25	Exterior Door			1996	2,563						25
26	Shower Tile			1996	806						26
27	Kitchen Heat/Cool Unit			1996	14,062						27
28	Resident Room Painting			1996	2,067						28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							10,579	10,579		34
35	Book Depreciation					110,118		110,118		1,080,802	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-Mendota

# 0048108

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	Garbage Disposal	1997	\$ 2,030	\$		\$	\$	\$	37
38	Generator	1997	39,380						38
39	Parking Lot Asphalt	1997	2,210						39
40	Shower	1997	701						40
41									41
42	Kitchen Drain	1998	3,245						42
43	Walk in Cooler Repair	1998	2,215						43
44	A/C Unit	1998	1,615						44
45	Landscaping	1998	4,696						45
46									46
47	Door Alarm System	1999	11,750						47
48	Air Conditioning Condensing Unit	1999	1,027						48
49	Water Softener	1999	4,493						49
50									50
51	Air conditioner (3)	2000	2,221						51
52	Sprinklers	2000	1,864						52
53	Resident Room Doors (45)	2000	1,724						53
54	Facility Remodel -- Materials (see attached detail)	2000	410,365						54
55	Facility Remodel -- Labor (see attached detail)	2000	4,030						55
56	Facility Remodel -- Professional Fees (see attached detail)	2000	23,932						56
57	Facility Remodel -- Interior Design (see attached detail)	2000	36,998						57
58	Water Softener	2000	4,713						58
59									59
60	Parking Spaces	2001	1,452						60
61	Water Heater	2001	2,847						61
62									62
63	Water Heater	2002	3,816						63
64	Wood door	2002	677						64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,932,499	\$ 110,118		\$ 120,697	\$ 10,579	\$ 1,080,802	70

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

Facility Name &amp; ID Number Heritage Manor-Mendota

# 0048108

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,932,499	\$ 110,118		\$ 120,697	\$ 10,579	\$ 1,080,802	1
2	Furnace	2003	2,491						2
3	A/C Unit	2003	3,083						3
4	Condensing Unit	2003	1,353						4
5									5
6	Heat/Cool Unit	2004	2,498						6
7	Disposal	2004	989						7
8	Garage Repairs	2004	4,866						8
9	Compressor	2004	1,805						9
10	Emergency Outlets	2004	1,565						10
11	Furnace	2004	6,280						11
12									12
13	Exterior Door	2005	3,161						13
14	Holding Tank	2005	3,897						14
15	Smoke Detector	2005	1,919						15
16	A/C Unit	2005	4,248						16
17	Parking Lot	2005	68,313						17
18	Dumpster Pad	2005	1,547						18
19	Sidewalks	2005	7,850						19
20									20
21	Floor -- entry way	2006	19,178						21
22	Shower rehab	2006	6,246						22
23	Phone system	2006	1,836						23
24	A/C Unit	2006	2,201						24
25	Compressor	2006	1,642						25
26	Remodel TLC unit -- paint, wallpaper	2006	6,126						26
27	Parking Lot	2006	3,633						27
28	Roof	2006	148,938						28
29	Valance	2006	581						29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,238,745	\$ 110,118		\$ 120,697	\$ 10,579	\$ 1,080,802	34

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

Facility Name & ID Number Heritage Manor-Mendota

# 0048108

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	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		\$ 2,238,745	\$ 110,118		\$ 120,697	\$ 10,579	\$ 1,080,802	1
2	Metal Roof	2007	49,988						2
3	Door Alarm	2007	2,986						3
4	HVAC	2007	3,370						4
5	Sprinkler system	2007	101,380						5
6	Wander Alarm	2007	8,092						6
7	fire Alarm	2007	42,223						7
8	Water Heater	2007	3,820						8
9	Grab Bars	2007	4,193						9
10									10
11	Heat/Cool Units	2008	2,713						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)		\$ 2,457,510	\$ 110,118		\$ 120,697	\$ 10,579	\$ 1,080,802	34

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

Facility Name & ID Number Heritage Manor-Mendota

# 0048108

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	\$ 2,457,510	\$ 110,118		\$ 120,697	\$ 10,579	\$ 1,080,802		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)	\$ 2,457,510	\$ 110,118		\$ 120,697	\$ 10,579	\$ 1,080,802		34

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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	\$ 833,918	\$ 36,167	\$ 36,167	\$		\$ 672,457	71
72	Current Year Purchases	20,696						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 854,614	\$ 36,167	\$ 36,167	\$		\$ 672,457	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)	\$ 3,338,274	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 146,285	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 156,864	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,579	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,753,259	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: \$ 1,064 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.

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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-Mendota# 0048108

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	\$		\$ 137,941	\$		\$ 137,941	1
2	Licensed Speech and Language Development Therapist		hrs			2,405			2,405	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			136,735	949		137,684	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				213,841		213,841	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					30,000			30,000	13
14	TOTAL			\$		\$ 307,081	\$ 214,790		\$ 521,871	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-Mendota# 0048108Report 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	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 75,478	\$	1
2	Cash-Patient Deposits	12,388		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	691,131		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,721		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(547,233)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 263,485	\$	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>	\$ 263,485	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 129,378	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,388		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	195,467		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,291		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>	13,662		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 354,186	\$	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>	\$ 354,186	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (90,701)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 263,485	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (54,310)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (54,310)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(36,391)	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)	\$ (36,391)	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)	\$ (90,701)	24 *

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

Facility Name & ID Number Heritage Manor-Mendota# 0048108Report 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	\$ 4,666,752	1
2	Discounts and Allowances for all Levels	(1,475,661)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,191,091</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,113,305	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,113,305</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	571	12
13	Barber and Beauty Care	10,039	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	646	16
17	Sale of Drugs	344,465	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	218	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 355,939</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,401	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 4,401</b>	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>	<b>\$ 4,664,736</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	785,840	31
32	Health Care	2,408,954	32
33	General Administration	1,049,058	33
<b>B. Capital Expense</b>			
34	Ownership	449,491	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	7,784	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>	<b>\$ 4,701,127</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(36,391)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (36,391)</b>	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-Mendota

# 0048108

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	1,892	2,080	\$ 60,461	\$ 29.07	1
2	Assistant Director of Nursing	1,936	2,080	55,611	26.74	2
3	Registered Nurses	11,874	12,855	356,147	27.70	3
4	Licensed Practical Nurses	12,096	13,128	288,493	21.98	4
5	CNAs & Orderlies	47,467	50,149	671,564	13.39	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	5,629	6,146	70,837	11.53	10
11	Social Service Workers	1,814	2,042	32,369	15.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,221	20,518	214,630	10.46	15
16	Dishwashers					16
17	Maintenance Workers	3,406	4,045	54,977	13.59	17
18	Housekeepers	6,568	7,056	70,723	10.02	18
19	Laundry	6,434	6,843	60,469	8.84	19
20	Administrator			84,523		20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,214	8,337	143,728	17.24	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)	125,551	135,279	\$ 2,164,532 *	\$ 16.00	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		8,400		36
37	Medical Records Consultant		405		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,970		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		1,548		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,323		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	497	\$ 19,873		50
51	Licensed Practical Nurses	648	23,322		51
52	Certified Nurse Assistants/Aides	7,217	180,427		52
53	TOTAL (lines 50 - 52)	8,362	\$ 223,622		53

Facility Name & ID Number Heritage Manor-Mendota

# 0048108

Report Period Beginning: 01/01/08

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**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				
Catherine McDowell	admin	0	\$ 84,523	Workers' Compensation Insurance	\$ 66,323	IDPH License Fee	\$ 956				
				Unemployment Compensation Insurance	24,102	Advertising: Employee Recruitment	2,723				
				FICA Taxes	165,587	Health Care Worker Background Check					
				Employee Health Insurance	163,734	(Indicate # of checks performed )	1,080				
				Employee Meals		Patient Background Checks	6,662				
				Illinois Municipal Retirement Fund (IMRF)*			13,600				
					0		7,743				
					16,747	Dues & Subscriptions	6,792				
					31,641	License & Fees	1,396				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 84,523	TOTAL (agree to Schedule V, line 22, col.8)			\$ 468,134	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 18,714	
(List each licensed administrator separately.)								Less: Public Relations Expense		(7,743)	
								Non-allowable advertising		(895)	
								Yellow page advertising		(13,600)	
B. Administrative - Other											
Description			Amount								
			\$								
TOTAL (agree to Schedule V, line 17, col. 3)			\$								
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount				
Heritage Operations Group	Mgt Fee	\$ 209,194				Out-of-State Travel	\$				
		0									
		0				In-State Travel					
		0									
							3,080				
							30				
						Seminar Expense	2,170				
							(13,188)				
		0				Central Office	9,907				
adj legal to zero		5,669				Entertainment Expense	( )				
		0				(agree to Sch. V, line 24, col. 8)					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 214,863	TOTAL			\$	TOTAL			\$ 1,999
(If total legal fees exceed \$5,000, attach copy of invoices.)											

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7 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 Mendota 38364 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,203  
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. \$ 21,600
- (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.



