

Facility Name & ID Number Heritage Manor-Mount Sterling# 0048041 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>87</u>	Skilled (SNF)	<u>87</u>	<u>31,755</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>87</u>	TOTALS	<u>87</u>	<u>31,755</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>13,521</u>	<u>6,493</u>	<u>1,727</u>	<u>21,741</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>13,521</u>	<u>6,493</u>	<u>1,727</u>	<u>21,741</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.46%

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 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 07/2006

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

YES Date 07/2006 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided 1,727Medicare 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-Mount Sterling # 0048041 Report Period Beginning: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	160,186	14,361		174,547		174,547	4,789	179,336		1
2	Food Purchase		133,021		133,021		133,021		133,021		2
3	Housekeeping	72,389	13,925		86,314		86,314	18	86,332		3
4	Laundry	24,054	7,845		31,899		31,899		31,899		4
5	Heat and Other Utilities			99,470	99,470		99,470	1,685	101,155		5
6	Maintenance	42,069	38,048	31,096	111,213		111,213	11,993	123,206		6
7	Other (specify):*										7
8	TOTAL General Services	298,698	207,200	130,566	636,464		636,464	18,485	654,949		8
	B. Health Care and Programs										
9	Medical Director			2,500	2,500		2,500	1,955	4,455		9
10	Nursing and Medical Records	938,798	63,903	20,744	1,023,445		1,023,445		1,023,445		10
10a	Therapy		109,244	137,448	246,692	(114,539)	132,153	185,085	317,238		10a
11	Activities	23,282	2,499		25,781		25,781	1,259	27,040		11
12	Social Services	26,201		4,228	30,429		30,429		30,429		12
13	CNA Training							995	995		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	988,281	175,646	164,920	1,328,847	(114,539)	1,214,308	189,294	1,403,602		16
	C. General Administration										
17	Administrative	69,098			69,098		69,098	60,638	129,736		17
18	Directors Fees							6,459	6,459		18
19	Professional Services			129,207	129,207		129,207	(122,627)	6,580		19
20	Dues, Fees, Subscriptions & Promotions			78,865	78,865	(47,633)	31,232	(5,677)	25,555		20
21	Clerical & General Office Expenses	68,817	18,676	8,153	95,646		95,646	136,061	231,707		21
22	Employee Benefits & Payroll Taxes			262,425	262,425		262,425	27,806	290,231		22
23	Inservice Training & Education			3,103	3,103		3,103	(1,104)	1,999		23
24	Travel and Seminar			6,011	6,011		6,011	(4,012)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			41,072	41,072		41,072	9,668	50,740		26
27	Other (specify):*			500	500		500	(500)			27
28	TOTAL General Administration	137,915	18,676	529,336	685,927	(47,633)	638,294	106,712	745,006		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,424,894	401,522	824,822	2,651,238	(162,172)	2,489,066	314,491	2,803,557		29

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

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

Facility Name & ID Number Heritage Manor-Mount Sterling #0048041 Report Period Beginning: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation							100,357	100,357		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			12,998	12,998		12,998	70,303	83,301		32
33	Real Estate Taxes							37,964	37,964		33
34	Rent-Facility & Grounds			381,060	381,060		381,060	(371,624)	9,436		34
35	Rent-Equipment & Vehicles			4,977	4,977		4,977	1,609	6,586		35
36	Other (specify):*										36
37	TOTAL Ownership			399,035	399,035		399,035	(161,391)	237,644		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					114,539	114,539		114,539		39
40	Barber and Beauty Shops		31	30	61		61		61		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					47,633	47,633		47,633		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		31	30	61	162,172	162,233		162,233		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,424,894	401,553	1,223,887	3,050,334		3,050,334	153,100	3,203,434		45

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

Facility Name & ID Number Heritage Manor-Mount Sterling

0048041

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	(2,914)	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)	(1,698)	23		16
17	Non-Care Related Fees	(418)	20		17
18	Fines and Penalties				18
19	Entertainment	(12,719)	24		19
20	Contributions	(500)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(11,114)	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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,363)		\$	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)	182,463		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 182,463		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 153,100		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Mount Sterling

ID# 0048041

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		(1,698)	23
17		(418)	20
18			18
19			24
20		(500)	27
21			21
22		0	19
23			23
24		0	27
25		(11,114)	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	Total	(13,730)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Mount Sterling

0048041

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,789	0	0	0	0	0	0	0	0	4,789	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	18	0	0	0	0	0	0	0	0	18	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,685	0	0	0	0	0	0	0	0	1,685	5
6	Maintenance	0	0	11,993	0	0	0	0	0	0	0	0	11,993	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	18,485	0	0	0	0	0	0	0	0	18,485	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,955	0	0	0	0	0	0	0	0	1,955	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	185,085	0	0	0	0	0	0	0	0	0	185,085	10a
11	Activities	0	0	1,259	0	0	0	0	0	0	0	0	1,259	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	995	0	0	0	0	0	0	0	0	995	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	185,085	4,209	0	0	0	0	0	0	0	0	189,294	16
	C. General Administration													
17	Administrative	0	0	60,638	0	0	0	0	0	0	0	0	60,638	17
18	Directors Fees	0	0	6,459	0	0	0	0	0	0	0	0	6,459	18
19	Professional Services	0	(129,207)	6,580	0	0	0	0	0	0	0	0	(122,627)	19
20	Fees, Subscriptions & Promotions	(11,532)	0	5,855	0	0	0	0	0	0	0	0	(5,677)	20
21	Clerical & General Office Expenses	0	0	136,061	0	0	0	0	0	0	0	0	136,061	21
22	Employee Benefits & Payroll Taxes	0	0	27,806	0	0	0	0	0	0	0	0	27,806	22
23	Inservice Training & Education	(1,698)	0	594	0	0	0	0	0	0	0	0	(1,104)	23
24	Travel and Seminar	(12,719)	0	8,707	0	0	0	0	0	0	0	0	(4,012)	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	9,668	0	0	0	0	0	0	0	0	9,668	26
27	Other (specify):*	(500)	0	0	0	0	0	0	0	0	0	0	(500)	27
28	TOTAL General Administration	(26,449)	(129,207)	262,368	0	0	0	0	0	0	0	0	106,712	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,449)	55,878	285,062	0	0	0	0	0	0	0	0	314,491	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Mount Sterling # 0048041 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	91,061	0	9,296	0	0	0	0	0	0	0	100,357	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,914)	67,623	0	5,594	0	0	0	0	0	0	0	70,303	32
33	Real Estate Taxes	0	37,964	0	0	0	0	0	0	0	0	0	37,964	33
34	Rent-Facility & Grounds	0	(381,060)	0	9,436	0	0	0	0	0	0	0	(371,624)	34
35	Rent-Equipment & Vehicles	0	0	0	1,609	0	0	0	0	0	0	0	1,609	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,914)	(184,412)	0	25,935	0	(161,391)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(29,363)	(128,534)	285,062	25,935	0	153,100	45						

Facility Name & ID Number Heritage Manor-Mount Sterling

0048041

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		185,085	185,085
3	V						
4	V	19	Adjustment for Related Organization	Heritage Operations Group, LLC	0.00%		(129,207)
5	V						
6	V	34	Adjustment for Related Organization	Heritage Manor Real Estate, LLC	0.00%		(381,060)
7	V	33	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		37,964	37,964
8	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		61,400	61,400
9	V	30	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		91,061	91,061
10	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		6,223	6,223
11	V						
12	V						
13	V						
14	Total		\$ 510,267			\$ 381,733	\$ * (128,534)

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

Facility Name & ID Number Heritage Manor-Mount Sterling# 0048041Report 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%	\$ 4,789	\$ 4,789	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				18	18	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,685	1,685	19
20	V	6 Maintenance				11,993	11,993	20
21	V	7 Other				0		21
22	V	9 Medical Director				1,955	1,955	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,259	1,259	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				995	995	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				60,638	60,638	29
30	V	18 Directors Fees				6,459	6,459	30
31	V	19 Professional Services				6,580	6,580	31
32	V	20 Fees, Subscription, Promotions				5,855	5,855	32
33	V	21 Clerical & General Office Expenses				136,061	136,061	33
34	V	22 Employee Benefits & Payroll Taxes				27,806	27,806	34
35	V	23 Inservice Training & Education				594	594	35
36	V	24 Travel and Seminar				8,707	8,707	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				9,668	9,668	38
39	Total		\$			\$ 285,062	\$ * 285,062	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$		0.00%	\$ 0	\$	15
16	V	30 Depreciation				9,296	9,296	16
17	V	31 Amortization of Pre-Op & Org				0		17
18	V	32 Interest				5,594	5,594	18
19	V	33 Real Estate Taxes				0		19
20	V	34 Rent-Facility & Grounds				9,436	9,436	20
21	V	35 Rent-Equipment & Vehicles				1,609	1,609	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		\$			\$ 25,935	\$ *	25,935 39

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

Facility Name & ID Number Heritage Manor-Mount Sterling # 0048041 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					\$ 6,459	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	\$ 6,459		13

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

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

Facility Name & ID Number Heritage Manor-Mount Sterling

0048041

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	87	\$ 4,789	1
2	2	Food Purchase	Beds	2,634	25	0	0	87	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	87	18	3
4	4	Laundry	Beds	2,634	25	0	0	87	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	87	1,685	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	87	11,993	6
7	7	Other	Beds	2,634	25	0	0	87	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	87	1,955	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	87	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	87	1,259	10
11	12	Social Service	Beds	2,634	25	0	0	87	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	87	995	12
13	14	Program Transportation	Beds	2,634	25	0	0	87	0	13
14	15	Other	Beds	2,634	25	0	0	87	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	87	60,638	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	87	6,459	16
17	19	Professional Services	Beds	2,634	25	199,226	0	87	6,580	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	87	5,855	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	87	136,061	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	87	27,806	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	87	594	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	87	8,707	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	87	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	87	9,668	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 285,062	25

Facility Name & ID Number Heritage Manor-Mount Sterling

0048041

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	27	Other	Beds	2,634	87	\$	\$	87	\$	1
2	30	Depreciation	Beds	2,634	87	281,453		87	9,296	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	87			87		3
4	32	Interest	Beds	2,634	87	169,367		87	5,594	4
5	33	Real Estate Taxes	Beds	2,634	87			87		5
6	34	Rent-Facility & Grounds	Beds	2,634	87	285,687		87	9,436	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	87	48,715		87	1,609	7
8	36	Other	Beds	2,634	87			87		8
9	38	Medically Nec Transportation	Beds	2,634	87			87		9
10	39	Ancillary Service Centers	Beds	2,634	87			87		10
11	40	Barber and Beauty Shops	Beds	2,634	87			87		11
12	41	Coffee and Gift Shops	Beds	2,634	87			87		12
13	42	Other	Beds	2,634	87			87		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	\$		\$ 25,935	25

Facility Name & ID Number Heritage Manor-Mount Sterling # 0048041 Report Period Beginning: 01/01/08 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1	Bank of America		xx	Mortgage			\$	\$ 939,210	03/11	variable	\$ 61,400	1
2	Bank of America		xx	Loan Fees							6,223	2
3												3
4												4
5												5
Working Capital												
6	Bank of America		xx	Accounts Receivable							12,998	6
7												7
8												8
9	TOTAL Facility Related						\$	\$ 939,210			\$ 80,621	9
B. Non-Facility Related*												
10	Interest Income										(2,914)	10
11	Allocated Corporate										5,594	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 2,680	14
15	TOTALS (line 9+line14)						\$	\$ 939,210			\$ 83,301	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>Important, 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.)		\$ 37,964	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 37,964	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 37,964	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	<u>35,458</u>	<u>8</u>
	2004	<u>37,476</u>	<u>9</u>
	2005	<u>35,586</u>	<u>10</u>
	2006	<u>41,344</u>	<u>11</u>
	2007	<u>37,964</u>	<u>12</u>
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Heritage Manor-Mount Sterling

0048041 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,796 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>8,000</u>	1
2					2
3	TOTALS			\$ 8,000	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87				\$ 914,680	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	1987 Improvements			1987	17,047						9
10	1987 Improvements			1987	73,700						10
11	1988 Improvements			1988	25,324						11
12	1989 Improvements			1989	64,856						12
13	1990 Improvements			1990	14,699						13
14	1991 Improvements			1991	18,519						14
15	1992 Improvements			1992	18,102						15
16	1993 Improvements			1993	54,992						16
17	1994 Improvements			1994	114,380						17
18	1995 Improvements			1995	22,646						18
19	Fire Alarm System			1996	27,410						19
20	Electrical Wire--Resident Rooms			1996	2,675						20
21	Drainage System			1996	5,100						21
22	Code Alert			1996	6,916						22
23	Resident Room Remodel			1996	26,925						23
24	Physical Therapy Room Remodel			1996	6,725						24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							9,296	9,296		34
35	Book Depreciation					78,893		78,893		1,144,222	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Mount Sterling# 0048041

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	Shower/Remodel	1997	\$ 6,033	\$		\$	\$	\$	37
38	Air Conditioner	1997	1,365						38
39	Resident Room Remodel	1997	199,404						39
40									40
41	Garbage Disposal	1998	797						41
42									42
43	Gerator Repair	1999	5,712						43
44	Kitchen Air Conditioner	1999	1,450						44
45									45
46	Door Monitor System	2000	5,196						46
47	Water Heater	2000	3,995						47
48	Sink Installation & Faucet	2000	1,736						48
49									49
50	Water Main Repair	2001	2,308						50
51	Water Heater	2001	3,016						51
52									52
53	A/C Unit	2002	2,634						53
54									54
55	A/C Unit	2003	3,024						55
56	Seal Asphalt	2003	3,538						56
57	Roof	2003	9,616						57
58	Sewer Repair	2003	2,275						58
59	A/C Unit	2003	1,377						59
60	Door	2003	2,283						60
61	Water Softener	2003	1,375						61
62									62
63	Door Alarm	2004	900						63
64	Doors	2004	1,127						64
65	Kick Plates	2004	2,181						65
66	A/C Unit	2004	6,105						66
67	Water Softener	2004	4,197						67
68	Wallguard/Wallcoverings	2004	8,138						68
69	Carpet	2004	1,027						69
70	TOTAL (lines 4 thru 69)		\$ 1,695,505	\$ 78,893		\$ 88,189	\$ 9,296	\$ 1,144,222	70

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

Facility Name & ID Number Heritage Manor-Mount Sterling

0048041

Report Period Beginning:

01/01/08

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 12A, Carried Forward		\$ 1,695,505	\$ 78,893		\$ 88,189	\$ 9,296	\$ 1,144,222	1
2	Drainage System	2005	5,803						2
3	Beverage Center	2005	4,299						3
4	Gutters and downspouts	2005	2,485						4
5	Hvac	2005	4,259						5
6	A/C unit	2005	2,423						6
7	Wallguard coverings	2005	8,715						7
8	Window blinds	2005	631						8
9									9
10	A/C unit	2006	5,340						10
11	Concrete Replacement	2006	9,275						11
12	Floor tile	2006	2,046						12
13	North Wing floor replacement	2006	17,247						13
14	Remodel -- Paint/wallpaper	2006	9,212						14
15	Closet Door	2006	619						15
16									16
17	Overbed lights	2007	11,260						17
18	Smoke detectors	2007							18
19	Hot Water Boiler	2007	10,154						19
20	Hand rail	2007							20
21	HVAC	2007	6,945						21
22	Air Handler	2007	2,540						22
23	Water heater	2007	3,066						23
24	Water heater	2007	3,556						24
25	Windows - North wing	2007	28,691						25
26	North Wing floor replacement	2007	3,388						26
27	Gazebo	2007							27
28	Flooring	2007							28
29	Exit lights	2007							29
30	Water Line	2007	2,805						30
31	Adjustment--audit	2007	(2,033)						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,838,231	\$ 78,893		\$ 88,189	\$ 9,296	\$ 1,144,222	34

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

Facility Name & ID Number Heritage Manor-Mount Sterling

0048041

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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,838,231	\$ 78,893		\$ 88,189	\$ 9,296	\$ 1,144,222	1
2	Sprinklers -- closets	2008	14,878						2
3	Roof	2008	7,744						3
4	A/C Units	2008	2,610						4
5	Heat/cool Unit	2008	6,354						5
6	Trane A/C & air handling unit	2008	5,305						6
7	North Wing Remodel/South Wing	2008	9,048						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)		\$ 1,884,170	\$ 78,893		\$ 88,189	\$ 9,296	\$ 1,144,222	34

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

Facility Name & ID Number Heritage Manor-Mount Sterling

0048041

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,884,170	\$ 78,893		\$ 88,189	\$ 9,296	\$ 1,144,222	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)	\$ 1,884,170	\$ 78,893		\$ 88,189	\$ 9,296	\$ 1,144,222	34

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

Facility Name & ID Number Heritage Manor-Mount Sterling # 0048041 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	\$ 562,132	\$ 12,168	\$ 12,168	\$		\$ 460,098	71
72	Current Year Purchases	18,839						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 580,971	\$ 12,168	\$ 12,168	\$		\$ 460,098	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)	\$ 2,473,141	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 91,061	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 100,357	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,296	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,604,320	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 4,977 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$		\$ 65,675	\$		\$ 65,675	1
2	Licensed Speech and Language Development Therapist		hrs			9,348			9,348	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			56,674	456		57,130	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				108,788		108,788	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					5,751			5,751	13
14	TOTAL			\$		\$ 137,448	\$ 109,244		\$ 246,692	14

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

Facility Name & ID Number Heritage Manor-Mount Sterling# 0048041Report 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 10,848	\$	1
2	Cash-Patient Deposits	20,492		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	425,328		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,636		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(522,901)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (47,597)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (47,597)	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 103,284	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,492		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,591		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,267		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>IPA Tax</u>	12,006		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 276,640	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 276,640	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (324,237)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (47,597)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (91,826)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (91,826)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(232,411)	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)	\$ (232,411)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (324,237)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Mount Sterling

0048041

Report Period Beginning: 01/01/08

Ending: 12/31/08

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,785,991	1
2	Discounts and Allowances for all Levels	(615,891)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,170,100	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	453,475	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 453,475	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	720	12
13	Barber and Beauty Care	408	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	190,306	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 191,434	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,914	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,914	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,817,923	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	636,464	31
32	Health Care	1,328,847	32
33	General Administration	685,927	33
B. Capital Expense			
34	Ownership	399,035	34
C. Ancillary Expense			
35	Special Cost Centers	61	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,050,334	40
41	Income before Income Taxes (line 30 minus line 40)**	(232,411)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (232,411)	43

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

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

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

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

Facility Name & ID Number Heritage Manor-Mount Sterling

0048041

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	1,753	1,840	\$ 44,613	\$ 24.25	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	889	1,049	22,131	21.10	3
4	Licensed Practical Nurses	16,749	17,649	334,079	18.93	4
5	CNAs & Orderlies	38,007	40,749	493,673	12.11	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,676	2,758	44,302	16.06	8
9	Activity Director					9
10	Activity Assistants	1,911	2,063	23,282	11.29	10
11	Social Service Workers	1,468	2,123	26,201	12.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,212	15,584	160,186	10.28	15
16	Dishwashers					16
17	Maintenance Workers	2,972	3,052	42,069	13.78	17
18	Housekeepers	7,838	8,710	72,389	8.31	18
19	Laundry	1,878	1,992	24,054	12.08	19
20	Administrator	1,900	2,080	69,098	33.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,789	4,152	68,817	16.57	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)	96,042	103,801	\$ 1,424,894 *	\$ 13.73	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	2,500		36
37	Medical Records Consultant	1,420		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,610		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	4,228		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 10,758		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0		50
51	Licensed Practical Nurses	474	16,585	51
52	Certified Nurse Assistants/Aides	0		52
53	TOTAL (lines 50 - 52)	474	\$ 16,585	53

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 Mt. Sterling 38273 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 47,633
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 0
- (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.

