

		FOR BHF USE					

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**2009**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2009)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>48918</u></p> <p><b>Facility Name:</b> <u>Barton W Stone - Jacksonville, LLC.</u></p> <p><b>Address:</b> <u>873 Grove Street</u> <u>Jacksonville</u>        Number City Zip Code</p> <p><b>County:</b> <u>Morgan</u></p> <p><b>Telephone Number:</b> <u>( 217)479-3400</u> Fax # <u>( )</u></p> <p><b>HFS ID Number:</b> <u>20-5298969001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>07/2007</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>          </u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other <u>          </u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other <u>          </u></td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Craig Ater</u> <b>Telephone Number:</b> <u>( 309 )823-7135</u>  <b>Email Address:</b> <u>cater@heritageofcare.com</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>          </u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u>          </u>		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u>          </u>		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Craig L. Ater</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Exec V.P. &amp; CFO</u></td> </tr> <tr> <td rowspan="5"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Craig L. Ater</u> <u>Exec V.P. &amp; CFO</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Heritage Operations Group, LLC.</u></td> </tr> <tr> <td>(Telephone) <u>( )</u> Fax # <u>( )</u></td> </tr> <tr> <td>MAIL TO: BUREAU OF HEALTH FINANCE        ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES        201 S. Grand Avenue East        Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>Craig L. Ater</u> (Date) _____		(Title) <u>Exec V.P. &amp; CFO</u>	<b>Paid Preparer</b>	(Signed) _____	(Print Name and Title) <u>Craig L. Ater</u> <u>Exec V.P. &amp; CFO</u>	(Firm Name & Address) <u>Heritage Operations Group, LLC.</u>	(Telephone) <u>( )</u> Fax # <u>( )</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																		
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Facility Name & ID Number Barton W Stone - Jacksonville, LLC.

# 48918 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	185	Skilled (SNF)	185	67,525	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	24	Sheltered Care (SC)	24	8,760	5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	76,285	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	29,530	22,527	7,361	59,418	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	725	2,595		3,320	12
13	DD 16 OR LESS					13
14	TOTALS	30,255	25,122	7,361	62,738	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.24%

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

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

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

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

none

F. Does the facility maintain a daily midnight census?

yes

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

YES  NO

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

YES  NO

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

Date started 07/2007

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

YES  Date \_\_\_\_\_ NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 7,361

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

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

Facility Name & ID Number Barton W Stone - Jacksonville, LLC. # 48918 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**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	498,845	23,708		522,553		522,553	8,150	530,703		1
2	Food Purchase		341,580		341,580		341,580	2	341,582		2
3	Housekeeping	248,369	29,539		277,908		277,908		277,908		3
4	Laundry	112,627	25,994		138,621		138,621		138,621		4
5	Heat and Other Utilities			279,793	279,793		279,793	4,174	283,967		5
6	Maintenance	131,649	127,803	81,596	341,048		341,048	41,612	382,660		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>991,490</b>	<b>548,624</b>	<b>361,389</b>	<b>1,901,503</b>		<b>1,901,503</b>	<b>53,938</b>	<b>1,955,441</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director							4,050	4,050		9
10	Nursing and Medical Records	3,434,321	246,185	90,010	3,770,516		3,770,516		3,770,516		10
10a	Therapy		625,792	954,769	1,580,561	(693,504)	887,057	356,339	1,243,396		10a
11	Activities	129,544	6,685		136,229		136,229	1,814	138,043		11
12	Social Services	70,107		5,666	75,773		75,773		75,773		12
13	CNA Training	4,528	744		5,272		5,272	2,965	8,237		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,638,500</b>	<b>879,406</b>	<b>1,050,445</b>	<b>5,568,351</b>	<b>(693,504)</b>	<b>4,874,847</b>	<b>365,168</b>	<b>5,240,015</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	95,900			95,900		95,900		95,900		17
18	Directors Fees										18
19	Professional Services			481,891	481,891		481,891	(456,332)	25,559		19
20	Dues, Fees, Subscriptions & Promotions			151,053	151,053	(101,288)	49,765	5,045	54,810		20
21	Clerical & General Office Expenses	375,802	38,444	23,821	438,067		438,067	513,367	951,434		21
22	Employee Benefits & Payroll Taxes			1,012,630	1,012,630		1,012,630	67,407	1,080,037		22
23	Inservice Training & Education			6,794	6,794		6,794	2,111	8,905		23
24	Travel and Seminar			9,748	9,748		9,748	18,958	28,706		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			111,145	111,145		111,145	22,523	133,668		26
27	Other (specify):*			6,124	6,124		6,124	(6,000)	124		27
28	<b>TOTAL General Administration</b>	<b>471,702</b>	<b>38,444</b>	<b>1,803,206</b>	<b>2,313,352</b>	<b>(101,288)</b>	<b>2,212,064</b>	<b>167,079</b>	<b>2,379,143</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>5,101,692</b>	<b>1,466,474</b>	<b>3,215,040</b>	<b>9,783,206</b>	<b>(794,792)</b>	<b>8,988,414</b>	<b>586,185</b>	<b>9,574,599</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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							375,856	375,856			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,730	21,730		21,730	229,379	251,109			32
33	Real Estate Taxes							84,129	84,129			33
34	Rent-Facility & Grounds			1,030,060	1,030,060		1,030,060	(1,017,092)	12,968			34
35	Rent-Equipment & Vehicles			16,060	16,060		16,060	3,444	19,504			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,067,850	1,067,850		1,067,850	(324,284)	743,566			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					693,504	693,504		693,504			39
40	Barber and Beauty Shops			38,439	38,439		38,439		38,439			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					101,288	101,288		101,288			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			38,439	38,439	794,792	833,231		833,231			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,101,692	1,466,474	4,321,329	10,889,495		10,889,495	261,901	11,151,396			45

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



Barton W Stone - Jacksonville, LLC.

ID# 48918

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(2,139)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(18,228)	19	22
23				23
24		(6,000)	27	24
25		(9,451)	20	25
26				26
27				27
28				28
29		0	33	29
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>	<b>(35,818)</b>		<b>49</b>

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Barton W Stone - Jacksonville, LLC.# 48918

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	8,150	0	0	0	0	0	0	0	0	8,150	1
2	Food Purchase	0	0	2	0	0	0	0	0	0	0	0	2	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	4,174	0	0	0	0	0	0	0	0	4,174	5
6	Maintenance	0	0	41,612	0	0	0	0	0	0	0	0	41,612	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	53,938	0	0	0	0	0	0	0	0	53,938	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	4,050	0	0	0	0	0	0	0	0	4,050	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	356,339	0	0	0	0	0	0	0	0	0	356,339	10a
11	Activities	0	0	1,814	0	0	0	0	0	0	0	0	1,814	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	2,965	0	0	0	0	0	0	0	0	2,965	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	356,339	8,829	0	0	0	0	0	0	0	0	365,168	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,228)	(463,663)	25,559	0	0	0	0	0	0	0	0	(456,332)	19
20	Fees, Subscriptions & Promotions	(11,590)	0	16,635	0	0	0	0	0	0	0	0	5,045	20
21	Clerical & General Office Expenses	0	0	513,367	0	0	0	0	0	0	0	0	513,367	21
22	Employee Benefits & Payroll Taxes	0	0	67,407	0	0	0	0	0	0	0	0	67,407	22
23	Inservice Training & Education	0	0	2,111	0	0	0	0	0	0	0	0	2,111	23
24	Travel and Seminar	0	0	18,958	0	0	0	0	0	0	0	0	18,958	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	22,523	0	0	0	0	0	0	0	0	22,523	26
27	Other (specify):*	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	27
28	<b>TOTAL General Administration</b>	(35,818)	(463,663)	666,560	0	0	0	0	0	0	0	0	167,079	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(35,818)	(107,324)	729,327	0	0	0	0	0	0	0	0	586,185	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Barton W Stone - Jacksonville, LLC.# 48918

Report Period Beginning:

01/01/2009 Ending:12/31/2009

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

	Capital Expense	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>D. Ownership</b>													
30	Depreciation	0	356,036	0	19,820	0	0	0	0	0	0	0	375,856	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,433)	232,118	0	694	0	0	0	0	0	0	0	229,379	32
33	Real Estate Taxes	0	84,129	0	0	0	0	0	0	0	0	0	84,129	33
34	Rent-Facility & Grounds	0	(1,030,060)	0	12,968	0	0	0	0	0	0	0	(1,017,092)	34
35	Rent-Equipment & Vehicles	0	0	0	3,444	0	0	0	0	0	0	0	3,444	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,433)</b>	<b>(357,777)</b>	<b>0</b>	<b>36,926</b>	<b>0</b>	<b>(324,284)</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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(39,251)	(465,101)	729,327	36,926	0	0	0	0	0	0	0	261,901	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Heritage Enterprises, Inc.</u>	<u>100%</u>	<u>See Attached</u>				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$		1
2	V	<u>10a Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>356,339</u>	<u>356,339</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>463,663</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(463,663)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>1,030,060</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(1,030,060)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>84,129</u>	<u>84,129</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>210,030</u>	<u>210,030</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>356,036</u>	<u>356,036</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>22,088</u>	<u>22,088</u>	10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		<b>\$ 1,493,723</b>			<b>\$ 1,028,622</b>	<b>\$ * (465,101)</b>	14

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

Facility Name & ID Number Barton W Stone - Jacksonville, LLC.# 48918Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## 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%	\$	\$	8,150	15	
16	V	2 Food Purchase						2	16	
17	V	3 Housekeeping						0	17	
18	V	4 Laundry						0	18	
19	V	5 Heat & Other Utilities						4,174	19	
20	V	6 Maintenance						41,612	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						4,050	22	
23	V	10 Nursing & Medical Records						0	23	
24	V	11 Activities						1,814	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						2,965	26	
27	V	14 Program Transportation						0	27	
28	V	15 Other						0	28	
29	V	17 Administrative						0	29	
30	V	18 Directors Fees						0	30	
31	V	19 Professional Services						25,559	31	
32	V	20 Fees, Subscription, Promotions						16,635	32	
33	V	21 Clerical & General Office Expenses						513,367	33	
34	V	22 Employee Benefits & Payroll Taxes						67,407	34	
35	V	23 Inservice Training & Education						2,111	35	
36	V	24 Travel and Seminar						18,958	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						22,523	38	
39	Total		\$			\$	0	\$ *	729,327	39

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

Facility Name & ID Number Barton W Stone - Jacksonville, LLC.

# 48918

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	0	15	
16	V	30 Depreciation						19,820	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						694	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						12,968	20	
21	V	35 Rent-Equipment & Vehicles						3,444	21	
22	V	36 Other						0	22	
23	V	38 Medically Nec Transportation						0	23	
24	V	39 Ancillary Service Centers						0	24	
25	V	40 Barber and Beauty Shops						0	25	
26	V	41 Coffee and Gift Shops						0	26	
27	V	42 Other						0	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total		\$			\$	0	\$ *	36,926	39

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

Facility Name & ID Number Barton W Stone - Jacksonville, LLC. # 48918 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## 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					\$ 0	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	\$		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 Barton W Stone - Jacksonville, LLC.

# 48918

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 102,708	\$ 102,349	209	\$ 8,150	1
2	2	Food Purchase	Beds	2,634	25	29	0	209	2	2
3	3	Housekeeping	Beds	2,634	25	0	0	209	0	3
4	4	Laundry	Beds	2,634	25	0	0	209	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	209	4,174	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	209	41,612	6
7	7	Other	Beds	2,634	25	0	0	209	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	209	4,050	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	209	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	209	1,814	10
11	12	Social Service	Beds	2,634	25	0	0	209	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	209	2,965	12
13	14	Program Transportation	Beds	2,634	25	0	0	209	0	13
14	15	Other	Beds	2,634	25	0	0	209	0	14
15	17	Administrative	Beds	2,634	25	0	0	209	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	209	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	209	25,559	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	209	16,635	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	209	513,367	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	209	67,407	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	209	2,111	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	209	18,958	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	209	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	209	22,523	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 729,327	25

Facility Name & ID Number Barton W Stone - Jacksonville, LLC.

# 48918

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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	25	\$	209	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	209	19,820	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		209		3
4	32	Interest	Beds	2,634	25	8,747	209	694	4
5	33	Real Estate Taxes	Beds	2,634	25		209		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	209	12,968	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	209	3,444	7
8	36	Other	Beds	2,634	25		209		8
9	38	Medically Nec Transportation	Beds	2,634	25		209		9
10	39	Ancillary Service Centers	Beds	2,634	25		209		10
11	40	Barber and Beauty Shops	Beds	2,634	25		209		11
12	41	Coffee and Gift Shops	Beds	2,634	25		209		12
13	42	Other	Beds	2,634	25		209		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				\$ 465,371	\$		\$ 36,926	25

Facility Name & ID Number

Barton W Stone - Jacksonville, LLC.

# 48918

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Bank of America		xx	Mortgage			\$	\$ 3,511,667	03/11	variable	\$ 210,030	1							
2	Bank of America		xx	Loan Fees							22,088	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Bank of America		xx	Accounts Receivable							21,730	6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$	\$ 3,511,667			\$ 253,848	9							
<b>B. Non-Facility Related*</b>																			
10	Interest Income										(3,433)	10							
11	Allocated Corporate										694	11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (2,739)	14							
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 3,511,667			\$ 251,109	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.)





Facility Name & ID Number Barton W Stone - Jacksonville, LLC.

# 48918

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 20,804 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>100,000</u>	1
2					2
3	TOTALS			\$ <u>100,000</u>	3

**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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	209			\$ 3,295,725	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Facility Sign		2005	1,050					
10	Dietary cabinets		2005	5,864					
11	Ansul system		2005	1,600					
12	Heat detectors		2005	1,777					
13	Door system		2005	17,554					
14	A/C units		2005	10,456					
15	Thurnbury door		2005	1,593					
16	Computer wiring		2005	1,280					
17	A/C compressor		2005	2,849					
18	Shelter care remodel-- paint, flooring, wallpaper		2006	225,040					
19	landscapping		2006	2,262					
20	Boiler		2006	2,580					
21	Heat/cool units		2006	9,517					
22	Fire alarm		2006	2,097					
23	Roof		2006	145,352					
24	Door system		2006	414					
25	Mixing Valve		2006	5,060					
26	Hutton Hall remodel (Shelter Care) -- Window treatments, painting		2006	31,147					
27	sump pump		2006	2,001					
28									
29									
30									
31									
32									
33									
34							19,820	19,820	
35					198,896		198,896		758,912
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 Barton W Stone - Jacksonville, LLC.

# 48918

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Backflow preventer	2007	\$ 3,501	\$		\$	\$	\$	37
38	Shower/faucet	2007	875						38
39	Air Handler	2007	5,215						39
40	HVAC	2007	20,152						40
41	Tree removal	2007	9,491						41
42	Valance	2007	581						42
43	Younkin corridor remodel -- paint	2007	16,420						43
44	Trane compressor	2007	2,841						44
45	Elevator	2007							45
46	Parking lot	2007							46
47	Door alarm	2007							47
48	fire dampers	2007							48
49	concrete pad	2007							49
50	Sprinkler system	2007							50
51									51
52	Nurse Call System	2008	206,839						52
53	Mechanical systems	2008	12,996						53
54	Condensing Unit	2008	17,965						54
55	Laundry plumbing	2008	12,671						55
56	Heat / Cool units	2008	24,201						56
57	Fire Panel	2008	7,378						57
58	Water Heater	2008	5,272						58
59	Kitchen Air Handler	2008	26,187						59
60	Condensing Unit	2008	4,069						60
61	Wireless Phone system	2008	44,744						61
62	Cables-nurse call	2008	22,788						62
63	Resident Phones	2008	10,081						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,219,485	\$ 198,896		\$ 218,716	\$ 19,820	\$ 758,912	70

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

Facility Name & ID Number Barton W Stone - Jacksonville, LLC.

# 48918

Report Period Beginning:

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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		\$ 4,219,485	\$ 198,896		\$ 218,716	\$ 19,820	\$ 758,912	1
2	Compressor	2009	2,516						2
3	Condensing Unit	2009	16,946						3
4	Boiler Replacement	2009	10,434						4
5	Roof	2009	8,393						5
6	HVAC units	2009	5,735						6
7	Firewall	2009	6,951						7
8	HVAC units	2009	5,106						8
9	Laundry plumbing	2009	7,351						9
10	Sewer ejector	2009	5,189						10
11	Dinning room paint, flooring & labor	2009	55,148						11
12	Cabling	2009	10,874						12
13	Laundry plumbing	2009	7,015						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)		\$ 4,361,143	\$ 198,896		\$ 218,716	\$ 19,820	\$ 758,912	34

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

Facility Name & ID Number **Barton W Stone - Jacksonville, LLC.**

# **48918**

Report Period Beginning:

**01/01/2009**

Ending:

**12/31/2009**

**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	\$ 1,080,600	\$ 157,140	\$ 157,140	\$		\$ 662,782	71
72	Current Year Purchases	51,076						72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 1,131,676	\$ 157,140	\$ 157,140	\$		\$ 662,782	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 5,592,819	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 356,036	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 375,856	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,820	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,421,694	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	<b>TOTALS</b>	\$	\$	\$	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

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: \$ 16,060 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

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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		744		744
3	Classroom Wages (a)				
4	Clinical Wages (b)		4,528		4,528
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 5,272	\$	\$ 5,272
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	5,272		

**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.

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	\$		\$ 408,943	\$		\$ 408,943	1
2	Licensed Speech and Language Development Therapist		hrs			73,410			73,410	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			404,413	291		404,704	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				625,501		625,501	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					68,003			68,003	13
14	<b>TOTAL</b>			\$		\$ 954,769	\$ 625,792		\$ 1,580,561	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 Barton W Stone - Jacksonville, LLC.# 48918Report Period Beginning: 01/01/2009Ending: 12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ 12,621	\$	1
2	Cash-Patient Deposits	13,181		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,018,552		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,280		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,546,830)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (497,196)	\$	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>	\$ (497,196)	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 293,158	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,181		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	527,486		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,094		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				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 844,919	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	220,250		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>	\$ 220,250	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,065,169	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,562,365)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (497,196)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,208,893)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,208,893)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(353,472)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(353,472)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,562,365)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Barton W Stone - Jacksonville, LLC.

# 48918

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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	\$ 9,867,937	1
2	Discounts and Allowances for all Levels	(3,410,726)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,457,211</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,732,565	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,732,565</b>	<b>8</b>
<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	8,140	12
13	Barber and Beauty Care	61,772	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,116,105	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	20,852	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,206,869</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,433	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 3,433</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Other</b>	135,945	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 135,945</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 10,536,023</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,901,503	31
32	Health Care	5,568,351	32
33	General Administration	2,313,352	33
<b>B. Capital Expense</b>			
34	Ownership	1,067,850	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	38,439	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>\$ 10,889,495</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(353,472)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (353,472)</b>	<b>43</b>

\* 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 **Barton W Stone - Jacksonville, LLC.**

# **48918**

Report Period Beginning: **01/01/2009**

Ending:

**12/31/2009**

**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	1,880	2,080	\$ 63,176	\$ 30.37	1
2	Assistant Director of Nursing	3,740	4,232	107,843	25.48	2
3	Registered Nurses	5,833	5,957	169,176	28.40	3
4	Licensed Practical Nurses	49,880	53,369	1,126,388	21.11	4
5	CNAs & Orderlies	145,552	153,967	1,905,951	12.38	5
6	CNA Trainees	400	400	4,528	11.32	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,256	3,458	61,787	17.87	8
9	Activity Director					9
10	Activity Assistants	10,988	11,746	129,544	11.03	10
11	Social Service Workers	3,732	4,193	70,107	16.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	43,071	46,702	498,845	10.68	15
16	Dishwashers					16
17	Maintenance Workers	9,603	10,208	131,649	12.90	17
18	Housekeepers	25,220	24,734	248,369	10.04	18
19	Laundry	9,382	10,281	112,627	10.95	19
20	Administrator	1,900	2,080	95,900	46.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,745	20,503	375,802	18.33	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)	333,182	353,910	\$ 5,101,692 *	\$ 14.42	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	0		36
37	Medical Records Consultant	7,407		37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,270		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	5,666		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 19,343		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0	50
51	Licensed Practical Nurses	752	26,307	51
52	Certified Nurse Assistants/Aides	1,882	47,042	52
53	TOTAL (lines 50 - 52)	2,633	\$ 73,349	53





Facility Name & ID Number Barton W Stone - Jacksonville, LLC.# 48918Report Period Beginning: 01/01/2009 Ending: 12/31/2009**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 Health Care 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? 7yrs
- (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.  
Barton Stone Home 46938 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 101,288  
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? no 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. \$ 1,331
- (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
- (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.