



Facility Name & ID Number Heritage Manor-Beardstown East

# 0048835 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	71	Skilled (SNF)	71	25,915	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	71	TOTALS	71	25,915	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	12,548	3,960	2,230	18,738	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,548	3,960	2,230	18,738	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.31%

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 2,230

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL  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 &amp; ID Number

Heritage Manor-Beardstown East

# 0048835

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	149,048	10,776		159,824		159,824	2,769	162,593		1
2	Food Purchase		127,681		127,681		127,681	1	127,682		2
3	Housekeeping	97,288	13,416		110,704		110,704		110,704		3
4	Laundry	25,524	9,923		35,447		35,447		35,447		4
5	Heat and Other Utilities			70,775	70,775		70,775	1,418	72,193		5
6	Maintenance	29,682	61,959	27,632	119,273		119,273	14,136	133,409		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	301,542	223,755	98,407	623,704		623,704	18,324	642,028		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800	1,376	6,176		9
10	Nursing and Medical Records	995,355	87,756	4,215	1,087,326		1,087,326		1,087,326		10
10a	Therapy		160,658	170,877	331,535	(172,761)	158,774	139,010	297,784		10a
11	Activities	40,665	3,412		44,077		44,077	616	44,693		11
12	Social Services	15,243		1,959	17,202		17,202		17,202		12
13	CNA Training							1,007	1,007		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,051,263	251,826	181,851	1,484,940	(172,761)	1,312,179	142,009	1,454,188		16
	<b>C. General Administration</b>										
17	Administrative	71,660			71,660		71,660		71,660		17
18	Directors Fees										18
19	Professional Services			133,819	133,819		133,819	(125,136)	8,683		19
20	Dues, Fees, Subscriptions & Promotions			72,664	72,664	(38,873)	33,791	(15,011)	18,780		20
21	Clerical & General Office Expenses	92,351	22,798	12,777	127,926		127,926	174,397	302,323		21
22	Employee Benefits & Payroll Taxes			256,731	256,731		256,731	22,899	279,630		22
23	Inservice Training & Education			3,495	3,495		3,495	717	4,212		23
24	Travel and Seminar			9,991	9,991		9,991	6,440	16,431		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			35,818	35,818		35,818	7,651	43,469		26
27	Other (specify):*			3,825	3,825		3,825	(3,825)			27
28	<b>TOTAL General Administration</b>	164,011	22,798	529,120	715,929	(38,873)	677,056	68,132	745,188		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,516,816	498,379	809,378	2,824,573	(211,634)	2,612,939	228,465	2,841,404		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-Beardstown East

#0048835

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

12/31/2009

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							103,586	103,586			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,341	8,341		8,341	54,290	62,631			32
33	Real Estate Taxes							32,155	32,155			33
34	Rent-Facility & Grounds			310,980	310,980		310,980	(306,575)	4,405			34
35	Rent-Equipment & Vehicles			1,576	1,576		1,576	1,170	2,746			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			320,897	320,897		320,897	(115,374)	205,523			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					172,761	172,761		172,761			39
40	Barber and Beauty Shops			16	16		16		16			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					38,873	38,873		38,873			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			16	16	211,634	211,650		211,650			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,516,816	498,379	1,130,291	3,145,486		3,145,486	113,091	3,258,577			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-Beardstown East

# 0048835

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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	(1,157)	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)		23		16
17	Non-Care Related Fees	(391)	20		17
18	Fines and Penalties				18
19	Entertainment		24		19
20	Contributions	(2,425)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,184)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,400)	27		24
25	Fund Raising, Advertising and Promotional	(20,271)	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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (32,828)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	145,919		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 145,919		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 113,091		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Beardstown East

ID# 0048835

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

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		(391)	20	17
18				18
19			24	19
20		(2,425)	27	20
21				21
22		(7,184)	19	22
23				23
24		(1,400)	27	24
25		(20,271)	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>		(31,671)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Beardstown East# 0048835

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	2,769	0	0	0	0	0	0	0	0	2,769	1
2	Food Purchase	0	0	1	0	0	0	0	0	0	0	0	1	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	1,418	0	0	0	0	0	0	0	0	1,418	5
6	Maintenance	0	0	14,136	0	0	0	0	0	0	0	0	14,136	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	18,324	0	0	0	0	0	0	0	0	18,324	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	1,376	0	0	0	0	0	0	0	0	1,376	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	139,010	0	0	0	0	0	0	0	0	0	139,010	10a
11	Activities	0	0	616	0	0	0	0	0	0	0	0	616	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,007	0	0	0	0	0	0	0	0	1,007	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	139,010	2,999	0	0	0	0	0	0	0	0	142,009	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	(7,184)	(126,635)	8,683	0	0	0	0	0	0	0	0	(125,136)	19
20	Fees, Subscriptions & Promotions	(20,662)	0	5,651	0	0	0	0	0	0	0	0	(15,011)	20
21	Clerical & General Office Expenses	0	0	174,397	0	0	0	0	0	0	0	0	174,397	21
22	Employee Benefits & Payroll Taxes	0	0	22,899	0	0	0	0	0	0	0	0	22,899	22
23	Inservice Training & Education	0	0	717	0	0	0	0	0	0	0	0	717	23
24	Travel and Seminar	0	0	6,440	0	0	0	0	0	0	0	0	6,440	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	7,651	0	0	0	0	0	0	0	0	7,651	26
27	Other (specify):*	(3,825)	0	0	0	0	0	0	0	0	0	0	(3,825)	27
28	<b>TOTAL General Administration</b>	(31,671)	(126,635)	226,438	0	0	0	0	0	0	0	0	68,132	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(31,671)	12,375	247,761	0	0	0	0	0	0	0	0	228,465	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Beardstown East# 0048835

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	96,853	0	6,733	0	0	0	0	0	0	0	103,586	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,157)	55,211	0	236	0	0	0	0	0	0	0	54,290	32
33	Real Estate Taxes	0	32,155	0	0	0	0	0	0	0	0	0	32,155	33
34	Rent-Facility & Grounds	0	(310,980)	0	4,405	0	0	0	0	0	0	0	(306,575)	34
35	Rent-Equipment & Vehicles	0	0	0	1,170	0	0	0	0	0	0	0	1,170	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,157)</b>	<b>(126,761)</b>	<b>0</b>	<b>12,544</b>	<b>0</b>	<b>(115,374)</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)	(32,828)	(114,386)	247,761	12,544	0	0	0	0	0	0	0	113,091	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>139,010</u>	<u>139,010</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>126,635</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(126,635)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>310,980</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(310,980)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>32,155</u>	<u>32,155</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>52,128</u>	<u>52,128</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>96,853</u>	<u>96,853</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>3,083</u>	<u>3,083</u>	10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		<b>\$ 437,615</b>			<b>\$ 323,229</b>	<b>\$ * (114,386)</b>	14

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

Facility Name & ID Number Heritage Manor-Beardstown East# 0048835Report 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%	\$	\$	2,769	15	
16	V	2 Food Purchase						1	16	
17	V	3 Housekeeping						0	17	
18	V	4 Laundry						0	18	
19	V	5 Heat & Other Utilities						1,418	19	
20	V	6 Maintenance						14,136	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						1,376	22	
23	V	10 Nursing & Medical Records						0	23	
24	V	11 Activities						616	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,007	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						8,683	31	
32	V	20 Fees, Subscription, Promotions						5,651	32	
33	V	21 Clerical & General Office Expenses						174,397	33	
34	V	22 Employee Benefits & Payroll Taxes						22,899	34	
35	V	23 Inservice Training & Education						717	35	
36	V	24 Travel and Seminar						6,440	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						7,651	38	
39	Total		\$			\$	0	\$ *	247,761	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	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	0 15
16	V	30 Depreciation						6,733 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						236 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						4,405 20
21	V	35 Rent-Equipment & Vehicles						1,170 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							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	<b>Total</b>		\$			\$	0	\$ * 12,544 39

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

Facility Name & ID Number Heritage Manor-Beardstown East # 0048835 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 Heritage Manor-Beardstown East

# 0048835

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

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	\$ 102,708	\$ 102,349	71	\$ 2,769	1
2	2	Food Purchase	Beds	2,634	25	29	0	71	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	71	0	3
4	4	Laundry	Beds	2,634	25	0	0	71	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	71	1,418	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	71	14,136	6
7	7	Other	Beds	2,634	25	0	0	71	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	71	1,376	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	71	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	71	616	10
11	12	Social Service	Beds	2,634	25	0	0	71	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	71	1,007	12
13	14	Program Transportation	Beds	2,634	25	0	0	71	0	13
14	15	Other	Beds	2,634	25	0	0	71	0	14
15	17	Administrative	Beds	2,634	25	0	0	71	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	71	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	71	8,683	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	71	5,651	18
19	21	Clerical & General Office Expens	Beds	2,634	25	6,469,900	6,230,337	71	174,397	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	71	22,899	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	71	717	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	71	6,440	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	71	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	71	7,651	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 247,761	25

Facility Name & ID Number Heritage Manor-Beardstown East

# 0048835

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	25	\$	71	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	71	6,733	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		71		3
4	32	Interest	Beds	2,634	25	8,747	71	236	4
5	33	Real Estate Taxes	Beds	2,634	25		71		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	71	4,405	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	71	1,170	7
8	36	Other	Beds	2,634	25		71		8
9	38	Medically Nec Transportation	Beds	2,634	25		71		9
10	39	Ancillary Service Centers	Beds	2,634	25		71		10
11	40	Barber and Beauty Shops	Beds	2,634	25		71		11
12	41	Coffee and Gift Shops	Beds	2,634	25		71		12
13	42	Other	Beds	2,634	25		71		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	\$		\$ 12,544	25

**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		3	4	5	6		8	9	10					
		Related**					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	Chase		xx	Mortgage			\$	\$ 812,845	03/11	variable	\$ 52,128	1				
2	Chase		xx	Loan Fees							3,083	2				
3												3				
4												4				
5												5				
<b>Working Capital</b>																
6	Bank of America		xx	Accounts Receivable							8,341	6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$	\$ 812,845			\$ 63,552	9				
<b>B. Non-Facility Related*</b>																
10	Interest Income										(1,157)	10				
11	Allocated Corporate										236	11				
12												12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (921)	14				
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 812,845			\$ 62,631	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**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>32,155</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>32,155</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>32,155</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>23,197</b>	8	
	2005	<b>27,608</b>	9	
	2006	<b>31,252</b>	10	
	2007	<b>31,816</b>	11	
	2008	<b>32,155</b>	12	
				<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2008 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor-Beardstown East COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0048835

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (      ) \_\_\_\_\_ FAX #: (      ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2008 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2008.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>0326400700</u>	<u>nursing home</u>	\$ <u>32,155.00</u>	\$ <u>32,155.00</u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>32,155.00</u>	\$ <u>32,155.00</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?             YES             NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 9,428 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>40,000</u>	1
2					2
3	TOTALS			\$ <u>40,000</u>	3

Facility Name &amp; ID Number Heritage Manor-Beardstown East

# 0048835

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**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	71				\$ 1,744,500	\$		\$	\$	\$
5										
6										
7										
8										
	<b>Improvement Type**</b>									
9		Shower Remodel		1997	9,921					
10		Heat/Cool Units		1997	2,138					
11		Roof		1997	101,691					
12		Interior Rehab		1997	87,411					
13										
14		Five Ton Heat Pump		1996	3,257					
15		Heritage Manor Sign		1996	2,145					
16		Remodel Physical Therapy Room		1996	18,303					
17										
18		Smoke Detectors		1998	5,431					
19		Back Flow Preventers		1998	3,155					
20		Interior Rehab		1998	144,749					
21										
22		Water Heater		1999	3,991					
23		Alzheimer Unit--material		1999	51,576					
24		Alzheimer Unit--Labor		1999	14,502					
25		Alzheimer Unit--Professional Fees		1999	21,605					
26		Interior Rehab		1999	30,944					
27										
28		Alzheimer Unit--material		2000	27,447					
29		Alzheimer Unit--Labor		2000	5,812					
30		Alzheimer Unit--Professional Fees		2000	1,310					
31		Fire Alarm Panel		2001	2,026					
32		Electric Door		2001	2,378					
33										
34		C/O Allocation						6,733	6,733	
35		Book Depreciation				82,346		82,346		993,497
36										

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Heritage Manor-Beardstown East

## 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	Heat/Cool Unit	2002	\$ 742	\$		\$	\$	\$	37
38	Heat/Cool Unit	2002	1,190						38
39									39
40	Heat Cool Unit	2003	104						40
41	Service Sink	2003	691						41
42	Security System	2003	2,160						42
43	Compressor	2003	2,244						43
44	Excerciser Clock	2003	1,243						44
45	A/C Unit	2003	568						45
46									46
47	Carpet	2004	3,280						47
48	Heat/Cool Unit	2004	2,877						48
49	Condensing Unit	2004	1,861						49
50	Electronic Door	2004	624						50
51									51
52	Ansul Sustem	2005	2,260						52
53	Hvac System	2005	2,620						53
54	Sidewalks	2005	7,106						54
55	Condensing Unit	2005	3,923						55
56	Shower repair	2005	320						56
57									57
58	condensor	2006	6,350						58
59	A/C Unit	2006	2,490						59
60	Fire barriers	2006	2,305						60
61	Water Heater	2006	3,850						61
62	Exterior door	2006	105						62
63	Fire Alarm panel	2006	1,401						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,334,606	\$ 82,346		\$ 89,079	\$ 6,733	\$ 993,497	70

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

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,334,606	\$ 82,346		\$ 89,079	\$ 6,733	\$ 993,497	1
2	Exterior Doors	2007	5,289						2
3	Landscaping	2007	15,880						3
4	Dinning Room Paint	2007	1,029						4
5	Fire Barrier	2007	1,703						5
6	Fire Alarm	2007	1,297						6
7	Doors	2007	1,950						7
8	Roof Shingles	2007	4,035						8
9	A/C unit	2007	528						9
10	Water Softener	2007	1,695						10
11									11
12	A/C Furnace Unit	2008	7,277						12
13	PTAC Unit	2008	3,062						13
14									14
15	Water Heater	2009	11,814						15
16	HVAC	2009	3,120						16
17	Water Softener	2009	4,792						17
18	HVAC	2009	16,866						18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,414,943	\$ 82,346		\$ 89,079	\$ 6,733	\$ 993,497	34

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

Facility Name & ID Number Heritage Manor-Beardstown East

# 0048835

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	\$ 329,832	\$ 14,507	\$ 14,507	\$		\$ 277,538	71
72	Current Year Purchases	2,410						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 332,242	\$ 14,507	\$ 14,507	\$		\$ 277,538	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)	\$ 2,787,185	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,853	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 103,586	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,733	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,271,035	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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

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

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 1,576 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.

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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	\$		\$ 63,827	\$		\$ 63,827	1
2	Licensed Speech and Language Development Therapist		hrs			24,933			24,933	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			69,095	919		70,014	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				159,739		159,739	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					13,022			13,022	13
14	<b>TOTAL</b>			\$		\$ 170,877	\$ 160,658		\$ 331,535	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-Beardstown East# 0048835Report Period Beginning: 01/01/2009

Ending:

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 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,212	\$	1
2	Cash-Patient Deposits	19,121		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	222,601		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,021		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,713,382)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (1,454,427)	\$	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>	\$ (1,454,427)	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 81,950	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,121		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,215		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,585		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>	\$ 219,871	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 219,871	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,674,298)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (1,454,427)	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (1,365,706)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (1,365,706)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(308,592)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (308,592)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>		23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (1,674,298)	24 *

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

Facility Name & ID Number Heritage Manor-Beardstown East# 0048835Report Period Beginning: 01/01/2009Ending: 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	\$ 2,936,664	1
2	Discounts and Allowances for all Levels	(959,301)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,977,363</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	557,535	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 557,535</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	789	12
13	Barber and Beauty Care	776	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	283,372	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,902	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 300,839</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,157	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,157</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,836,894</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	623,704	31
32	Health Care	1,484,940	32
33	General Administration	715,929	33
<b>B. Capital Expense</b>			
34	Ownership	320,897	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	16	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>\$ 3,145,486</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(308,592)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (308,592)</b>	43

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

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

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

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

Facility Name & ID Number Heritage Manor-Beardstown East

# 0048835

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	1,811	2,075	\$ 52,146	\$ 25.13	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	4,695	4,920	123,370	25.08	3
4	Licensed Practical Nurses	13,277	13,731	284,227	20.70	4
5	CNAs & Orderlies	40,860	43,898	496,553	11.31	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,903	2,076	39,059	18.81	8
9	Activity Director					9
10	Activity Assistants	3,707	3,993	40,665	10.18	10
11	Social Service Workers	1,250	1,250	15,243	12.19	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,086	15,436	149,048	9.66	15
16	Dishwashers					16
17	Maintenance Workers	1,965	2,052	29,682	14.46	17
18	Housekeepers	7,646	8,240	97,288	11.81	18
19	Laundry	1,838	2,092	25,524	12.20	19
20	Administrator	1,900	2,080	71,660	34.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,255	5,905	92,351	15.64	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)	100,193	107,748	\$ 1,516,816 *	\$ 14.08	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	4,800		36
37	Medical Records Consultant	1,075		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,130		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	1,959		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 9,964		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	0		51
52	Certified Nurse Assistants/Aides	0		52
53	TOTAL (lines 50 - 52)	\$		53





Facility Name & ID Number Heritage Manor-Beardstown East# 0048835Report 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.  
Heritage Manor Beardstown East 41632 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,873  
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.