

Facility Name & ID Number Heritage Manor-Beardstown South

0048843 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	79	Skilled (SNF)	79	28,835	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	79	TOTALS	79	28,835	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 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	13,585	4,840	3,309	21,734	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	13,585	4,840	3,309	21,734	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.37%

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)

SLF

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 3,309

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 Heritage Manor-Beardstown South # 0048843 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
	A. General Services										
1	Dietary	194,111	15,730		209,841		209,841	3,080	212,921		1
2	Food Purchase		181,165		181,165		181,165	1	181,166		2
3	Housekeeping	79,883	16,010		95,893		95,893		95,893		3
4	Laundry	46,071	9,131		55,202		55,202		55,202		4
5	Heat and Other Utilities			248,663	248,663		248,663	1,578	250,241		5
6	Maintenance	73,545	103,346	78,640	255,531		255,531	15,729	271,260		6
7	Other (specify):*										7
8	TOTAL General Services	393,610	325,382	327,303	1,046,295		1,046,295	20,388	1,066,683		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800	1,531	6,331		9
10	Nursing and Medical Records	951,570	122,277	5,744	1,079,591		1,079,591		1,079,591		10
10a	Therapy		189,219	224,896	414,115	(237,135)	176,980	154,205	331,185		10a
11	Activities	46,497	8,961		55,458		55,458	686	56,144		11
12	Social Services	40,253	154,722	4,520	199,495		199,495		199,495		12
13	CNA Training		4,289		4,289		4,289	1,121	5,410		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,038,320	479,468	239,960	1,757,748	(237,135)	1,520,613	157,543	1,678,156		16
	C. General Administration										
17	Administrative	71,077			71,077		71,077		71,077		17
18	Directors Fees										18
19	Professional Services			196,203	196,203		196,203	(186,542)	9,661		19
20	Dues, Fees, Subscriptions & Promotions			130,967	130,967	(70,656)	60,311	(36,516)	23,795		20
21	Clerical & General Office Expenses	120,824	28,625	13,963	163,412		163,412	194,048	357,460		21
22	Employee Benefits & Payroll Taxes			349,893	349,893		349,893	25,479	375,372		22
23	Inservice Training & Education			3,774	3,774		3,774	798	4,572		23
24	Travel and Seminar			14,576	14,576		14,576	7,166	21,742		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			43,956	43,956		43,956	8,514	52,470		26
27	Other (specify):*			18,910	18,910		18,910	(18,910)			27
28	TOTAL General Administration	191,901	28,625	772,242	992,768	(70,656)	922,112	(5,963)	916,149		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,623,831	833,475	1,339,505	3,796,811	(307,791)	3,489,020	171,968	3,660,988		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 South

#0048843

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							203,901	203,901			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,274	9,274		9,274	106,709	115,983			32
33	Real Estate Taxes							56,230	56,230			33
34	Rent-Facility & Grounds			459,900	459,900		459,900	(478,465)	(18,565)			34
35	Rent-Equipment & Vehicles			2,400	2,400		2,400	1,302	3,702			35
36	Other (specify):*											36
37	TOTAL Ownership			471,574	471,574		471,574	(110,323)	361,251			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers						237,135	237,135	237,135			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee						70,656	70,656	70,656			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers						307,791	307,791	307,791			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,623,831	833,475	1,811,079	4,268,385		4,268,385	61,645	4,330,030			45

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

Heritage Manor-Beardstown South

ID# 0048843

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		(699)	20	17
18				18
19			24	19
20		(2,510)	27	20
21				21
22		(10,665)	19	22
23				23
24		(16,400)	27	24
25		(42,105)	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	Total	(72,379)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Beardstown South# 0048843

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)	
	A. General Services													
1	Dietary	0	0	3,080	0	0	0	0	0	0	0	0	3,080	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	1,578	0	0	0	0	0	0	0	0	1,578	5
6	Maintenance	0	0	15,729	0	0	0	0	0	0	0	0	15,729	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	20,388	0	20,388	8							
	B. Health Care and Programs													
9	Medical Director	0	0	1,531	0	0	0	0	0	0	0	0	1,531	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	154,205	0	0	0	0	0	0	0	0	0	154,205	10a
11	Activities	0	0	686	0	0	0	0	0	0	0	0	686	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,121	0	0	0	0	0	0	0	0	1,121	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	154,205	3,338	0	157,543	16							
	C. General Administration													
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	(10,665)	(185,538)	9,661	0	0	0	0	0	0	0	0	(186,542)	19
20	Fees, Subscriptions & Promotions	(42,804)	0	6,288	0	0	0	0	0	0	0	0	(36,516)	20
21	Clerical & General Office Expenses	0	0	194,048	0	0	0	0	0	0	0	0	194,048	21
22	Employee Benefits & Payroll Taxes	0	0	25,479	0	0	0	0	0	0	0	0	25,479	22
23	Inservice Training & Education	0	0	798	0	0	0	0	0	0	0	0	798	23
24	Travel and Seminar	0	0	7,166	0	0	0	0	0	0	0	0	7,166	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	8,514	0	0	0	0	0	0	0	0	8,514	26
27	Other (specify):*	(18,910)	0	0	0	0	0	0	0	0	0	0	(18,910)	27
28	TOTAL General Administration	(72,379)	(185,538)	251,954	0	(5,963)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(72,379)	(31,333)	275,680	0	171,968	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Beardstown South# 0048843

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)	
	D. Ownership													
30	Depreciation	0	196,409	0	7,492	0	0	0	0	0	0	0	203,901	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(404)	106,851	0	262	0	0	0	0	0	0	0	106,709	32
33	Real Estate Taxes	0	56,230	0	0	0	0	0	0	0	0	0	56,230	33
34	Rent-Facility & Grounds	(23,467)	(459,900)	0	4,902	0	0	0	0	0	0	0	(478,465)	34
35	Rent-Equipment & Vehicles	0	0	0	1,302	0	0	0	0	0	0	0	1,302	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(23,871)	(100,410)	0	13,958	0	(110,323)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(96,250)	(131,743)	275,680	13,958	0	0	0	0	0	0	0	61,645	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>154,205</u>	<u>154,205</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>185,538</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(185,538)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>459,900</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(459,900)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>56,230</u>	<u>56,230</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>103,251</u>	<u>103,251</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>196,409</u>	<u>196,409</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>3,600</u>	<u>3,600</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>645,438</u>			\$ <u>513,695</u>	\$ * <u>(131,743)</u>	14

* 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	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	3,080	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						1,578	19	
20	V	6 Maintenance						15,729	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						1,531	22	
23	V	10 Nursing & Medical Records						0	23	
24	V	11 Activities						686	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,121	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						9,661	31	
32	V	20 Fees, Subscription, Promotions						6,288	32	
33	V	21 Clerical & General Office Expenses						194,048	33	
34	V	22 Employee Benefits & Payroll Taxes						25,479	34	
35	V	23 Inservice Training & Education						798	35	
36	V	24 Travel and Seminar						7,166	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						8,514	38	
39	Total		\$			\$	0	\$ *	275,680	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						7,492	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						262	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						4,902	20	
21	V	35 Rent-Equipment & Vehicles						1,302	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	\$ *	13,958	39

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

Facility Name & ID Number Heritage Manor-Beardstown South # 0048843 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 South

0048843

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	79	\$ 3,080	1
2	2	Food Purchase	Beds	2,634	25	29	0	79	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	79	0	3
4	4	Laundry	Beds	2,634	25	0	0	79	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	79	1,578	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	79	15,729	6
7	7	Other	Beds	2,634	25	0	0	79	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	79	1,531	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	79	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	79	686	10
11	12	Social Service	Beds	2,634	25	0	0	79	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	79	1,121	12
13	14	Program Transportation	Beds	2,634	25	0	0	79	0	13
14	15	Other	Beds	2,634	25	0	0	79	0	14
15	17	Administrative	Beds	2,634	25	0	0	79	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	79	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	79	9,661	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	79	6,288	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	79	194,048	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	79	25,479	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	79	798	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	79	7,166	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	79	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	79	8,514	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 275,680	25

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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	\$	79	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	79	7,492	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		79		3
4	32	Interest	Beds	2,634	25	8,747	79	262	4
5	33	Real Estate Taxes	Beds	2,634	25		79		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	79	4,902	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	79	1,302	7
8	36	Other	Beds	2,634	25		79		8
9	38	Medically Nec Transportation	Beds	2,634	25		79		9
10	39	Ancillary Service Centers	Beds	2,634	25		79		10
11	40	Barber and Beauty Shops	Beds	2,634	25		79		11
12	41	Coffee and Gift Shops	Beds	2,634	25		79		12
13	42	Other	Beds	2,634	25		79		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	\$	\$ 13,958	25

Facility Name & ID Number

Heritage Manor-Beardstown South

0048843

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			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America		xx	Mortgage			\$	\$ 1,775,044	03/11	variable	\$ 100,708	1							
2	Bank of America		xx	Loan Fees							3,600	2							
3	Bank of Springfield		xx	Van							2,543	3							
4												4							
5												5							
Working Capital																			
6	Bank of America		xx	Accounts Receivable							9,274	6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$ 1,775,044			\$ 116,125	9							
B. Non-Facility Related*																			
10	Interest Income										(404)	10							
11	Allocated Corporate										262	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (142)	14							
15	TOTALS (line 9+line14)						\$	\$ 1,775,044			\$ 115,983	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

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.)		\$	56,230	2
3. Under or (over) accrual (line 2 minus line 1).		\$	56,230	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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	56,230	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	64,022		8
	2005	55,026		9
	2006	55,812		10
	2007	65,459		11
	2008	56,230		12
	FOR BHF USE ONLY			
	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.

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,196 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).

Evergreen Place , Beardstown, Illinois
Supportive Living Facility (26 Apartments)

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>25,000</u>	1
2					2
3	TOTALS			\$ <u>25,000</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	79				\$ 1,380,636	\$		\$	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9	Remodel facility--Materials & Labor		1997		272,458					
10										
11	Nurse Call System		1997		1,500					
12										
13	Remodel facility--Materials & Labor		1998		85,772					
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27	Door Alarm System		2000		2,727					
28	A/C Compressor		2000		2,984					
29	Compressor -- Walk-in Freezer		2000		2,586					
30	Water Heater		2000		2,804					
31										
32										
33										
34	C/O Allocation							7,492	7,492	
35	Book Depreciation					143,253		143,253		
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Recirculating Pump	2001	\$ 889	\$		\$	\$	\$	37
38	West entrance Door	2001	1,700						38
39									39
40	Door	2002	2,840						40
41	a/c unit	2002	15,900						41
42	Shower room Wall	2002	1,200						42
43	Cmpressor	2002	13,348						43
44									44
45	Sewer Relocation	2002	2,011						45
46									46
47	Sewer Relocation	2003	2,206						47
48	a/c units	2003	10,170						48
49									49
50	Disposer	2003	1,454						50
51	A/C Unit	2003	5,786						51
52	Rebuild Generator	2003	4,276						52
53									53
54	Exterior doors	2004	3,212						54
55	Shower room Remodel	2004	9,028						55
56	Landscapping	2004	3,030						56
57	Canopy	2004	570						57
58	Door	2004	1,068						58
59	A/C Unit	2004	7,326						59
60	Heat/Cool Units	2004	6,960						60
61	Carpet	2004	911						61
62	Compressor	2004	2,949						62
63	Chiller	2004	1,970						63
64	Drier Core	2004	953						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,851,224	\$ 143,253		\$ 150,745	\$ 7,492	\$	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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,851,224	\$ 143,253		\$ 150,745	\$ 7,492	\$	1
2	Shower Remodel	2005	7,273						2
3	Ansul System	2005	2,540						3
4									4
5									5
6	Interior rehab -- Labor and Materials	2005	28,299						6
7	Delayed Egress Magnet	2005	2,092						7
8	Panic Door Hardware	2005	2,125						8
9	Roof repair	2005	3,702						9
10									10
11									11
12	Door opener	2006	2,445						12
13	Wanderguard system	2006	2,267						13
14	Hot water heater	2006	13,771						14
15	Sidewalk	2006	4,928						15
16									16
17	Hvac	2006	17,853						17
18									18
19	Alarm system	2006	6,568						19
20	Generator regulator	2006	1,727						20
21	Awning	2006	4,264						21
22	Closet door	2006	2,722						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,953,800	\$ 143,253		\$ 150,745	\$ 7,492	\$	34

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

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,953,800	\$ 143,253		\$ 150,745	\$ 7,492	\$	1
2	<u>HVAC</u>	2007	9,672						2
3	<u>Chiller</u>	2007	2,603						3
4									4
5	Post 6/30/07 capital review								5
6	<u>Landscaping</u>	2007	28,000						6
7	<u>Water Heater</u>	2007	21,682						7
8	<u>Rooftop A/C</u>	2007	205						8
9	<u>Blinds</u>	2007	845						9
10	<u>Roof fans</u>	2007	3,457						10
11	<u>A/C</u>	2007	12,487						11
12	<u>Doors</u>	2007	3,358						12
13	<u>Generator</u>	2007	39,004						13
14	<u>Wall Heater</u>	2007	3,384						14
15	<u>Circulating pump</u>	2007	896						15
16	<u>Roof</u>	2007	141,801						16
17									17
18	<u>HVAC Rooftop Unit</u>	2008	148,000						18
19	<u>Water Heater</u>	2008	14,252						19
20	<u>Heater Replacement</u>	2008	4,008						20
21	<u>Resident Room Remodel-- Painting, Lighting</u>	2008	75,015						21
22	<u>Hot Water Heater</u>	2008	6,621						22
23	<u>HVAC Units</u>	2008	19,280						23
24	<u>Electric Heater</u>	2008	5,195						24
25									25
26	<u>Elevator</u>	2009	9,873						26
27	<u>Mixing valve</u>	2009	3,715						27
28	<u>Room painting</u>	2009	6,065						28
29	<u>Comdensor</u>	2009	5,260						29
30	<u>Lights</u>	2009	4,055						30
31	<u>Parking Lot</u>	2009	83,790						31
32	<u>Flooring</u>	2009	18,770						32
33	<u>Nurse Call System</u>	2009	107,659						33
34	TOTAL (lines 1 thru 33)		\$ 2,732,752	\$ 143,253		\$ 150,745	\$ 7,492	\$	34

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

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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	\$ 758,377	\$ 53,156	\$ 53,156	\$		\$	71
72	Current Year Purchases	125,634						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 884,011	\$ 53,156	\$ 53,156	\$		\$	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		turtle top	2008	\$ 61,815	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 61,815	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,703,578	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 196,409	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 203,901	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,492	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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

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: \$ 2,400 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		4,289		4,289
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 4,289	\$	\$ 4,289
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,289		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$ 0	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs			21,360				21,360	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs			154,195	1,425			155,620	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				187,794			187,794	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):					49,341				49,341	13
14	TOTAL			\$		\$ 224,896	\$ 189,219		\$	414,115	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 South

0048843

Report 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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,957	\$	1
2	Cash-Patient Deposits	11,765		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	458,938		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,411		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(570,462)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (64,391)	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (64,391)	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 117,643	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,765		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	180,624		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,174		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 312,206	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 312,206	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (376,597)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (64,391)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (106,618)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (106,618)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(269,979)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (269,979)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (376,597)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,664,028	1
2	Discounts and Allowances for all Levels	(1,408,898)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,255,130	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,114,960	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,114,960	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	655	12
13	Barber and Beauty Care	700	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	23,467	16
17	Sale of Drugs	330,947	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,355	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 357,124	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	404	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 404	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,727,618	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,046,295	31
32	Health Care	1,757,748	32
33	General Administration	992,768	33
B. Capital Expense			
34	Ownership	471,574	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	Other	(270,788)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,997,597	40
41	Income before Income Taxes (line 30 minus line 40)**	(269,979)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (269,979)	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 South**

0048843

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	1,364	1,668	\$ 43,378	\$ 26.01	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	1,251	1,251	29,693	23.74	3
4	Licensed Practical Nurses	14,536	15,255	317,668	20.82	4
5	CNAs & Orderlies	37,654	40,587	513,757	12.66	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,139	2,271	47,074	20.73	8
9	Activity Director					9
10	Activity Assistants	3,856	4,170	46,497	11.15	10
11	Social Service Workers	2,050	2,304	40,253	17.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,229	18,117	194,111	10.71	15
16	Dishwashers					16
17	Maintenance Workers	5,043	5,633	73,545	13.06	17
18	Housekeepers	9,214	9,775	79,883	8.17	18
19	Laundry	1,897	2,605	46,071	17.69	19
20	Administrator	1,900	2,080	71,077	34.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,355	6,882	120,824	17.56	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)	104,488	112,598	\$ 1,623,831 *	\$ 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	4,800		36
37	Medical Records Consultant	1,520		37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,150		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	4,520		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 13,990		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 South# 0048843Report 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 38273 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 70,656
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.