

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0048850</u></p> <p>Facility Name: <u>Heritage Manor-Carlinville</u></p> <p>Address: <u>1200 University Avenue</u> <u>Carlinville</u> <u>62626</u> Number City Zip Code</p> <p>County: <u>Macoupin</u></p> <p>Telephone Number: <u>(217) 854-4433</u> Fax # ()</p> <p>HFS ID Number: <u>205508113001</u></p> <p>Date of Initial License for Current Owners: <u>07/2007</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Craig L. Ater</u> (Date) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Title) <u>Exec V.P. & CFO</u></td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Craig L. Ater</u> <u>Exec V.P. & CFO</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Heritage Operations Group, LLC.</u></td> </tr> <tr> <td></td> <td>(Telephone) () Fax # ()</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Craig L. Ater</u> (Date) _____	Paid Preparer	(Title) <u>Exec V.P. & CFO</u>	(Signed) _____	(Print Name and Title) <u>Craig L. Ater</u> <u>Exec V.P. & CFO</u>	(Firm Name & Address) <u>Heritage Operations Group, LLC.</u>		(Telephone) () Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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	(Firm Name & Address) <u>Heritage Operations Group, LLC.</u>																																		
	(Telephone) () Fax # ()																																		
<p>In the event there are further questions about this report, please contact: Name: <u>Craig Ater</u> Telephone Number: <u>(309) 823-7135</u> Email Address: <u>cater@heritageofcare.com</u></p>	<p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>																																		

Facility Name & ID Number Heritage Manor-Carlinville

0048850 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	108	Skilled (SNF)	108	39,420	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	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	13,343	8,775	2,549	24,667	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,343	8,775	2,549	24,667	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.57%

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 2,549

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-Carlinville # 0048850 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	175,151	10,362		185,513		185,513	4,211	189,724		1
2	Food Purchase		149,466		149,466		149,466	1	149,467		2
3	Housekeeping	112,076	18,127		130,203		130,203		130,203		3
4	Laundry	48,145	15,411		63,556		63,556		63,556		4
5	Heat and Other Utilities			128,643	128,643		128,643	2,157	130,800		5
6	Maintenance	62,809	58,016	33,062	153,887		153,887	21,503	175,390		6
7	Other (specify):*										7
8	TOTAL General Services	398,181	251,382	161,705	811,268		811,268	27,872	839,140		8
	B. Health Care and Programs										
9	Medical Director			3,000	3,000		3,000	2,093	5,093		9
10	Nursing and Medical Records	1,322,896	111,645	12,727	1,447,268		1,447,268		1,447,268		10
10a	Therapy		280,961	308,417	589,378	(290,756)	298,622	284,528	583,150		10a
11	Activities	52,491	2,468		54,959		54,959	937	55,896		11
12	Social Services	30,704		3,043	33,747		33,747		33,747		12
13	CNA Training	9,888	3,848		13,736		13,736	1,532	15,268		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,415,979	398,922	327,187	2,142,088	(290,756)	1,851,332	289,090	2,140,422		16
	C. General Administration										
17	Administrative	60,367			60,367		60,367		60,367		17
18	Directors Fees										18
19	Professional Services			176,345	176,345		176,345	(163,137)	13,208		19
20	Dues, Fees, Subscriptions & Promotions			94,668	94,668	(59,130)	35,538	(10,058)	25,480		20
21	Clerical & General Office Expenses	151,150	28,195	10,823	190,168		190,168	265,281	455,449		21
22	Employee Benefits & Payroll Taxes			492,327	492,327		492,327	34,832	527,159		22
23	Inservice Training & Education			3,342	3,342		3,342	1,091	4,433		23
24	Travel and Seminar			13,813	13,813		13,813	9,797	23,610		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			51,383	51,383		51,383	11,639	63,022		26
27	Other (specify):*			64	64		64	(64)			27
28	TOTAL General Administration	211,517	28,195	842,765	1,082,477	(59,130)	1,023,347	149,381	1,172,728		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,025,677	678,499	1,331,657	4,035,833	(349,886)	3,685,947	466,343	4,152,290		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-Carlinville

#0048850

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							184,201	184,201			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,676	12,676		12,676	39,039	51,715			32
33	Real Estate Taxes							41,701	41,701			33
34	Rent-Facility & Grounds			473,040	473,040		473,040	(466,339)	6,701			34
35	Rent-Equipment & Vehicles			11,736	11,736		11,736	1,779	13,515			35
36	Other (specify):*											36
37	TOTAL Ownership			497,452	497,452		497,452	(199,619)	297,833			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					290,756	290,756		290,756			39
40	Barber and Beauty Shops			7,703	7,703		7,703		7,703			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					59,130	59,130		59,130			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			7,703	7,703	349,886	357,589		357,589			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,025,677	678,499	1,836,812	4,540,988		4,540,988	266,724	4,807,712			45

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

Heritage Manor-Carlinville

ID# 0048850

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		(1,198)	20	17
18				18
19			24	19
20		(64)	27	20
21				21
22		(2,043)	19	22
23				23
24		0	27	24
25		(17,456)	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	(20,761)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Carlinville# 0048850

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	4,211	0	0	0	0	0	0	0	0	4,211	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	2,157	0	0	0	0	0	0	0	0	2,157	5
6	Maintenance	0	0	21,503	0	0	0	0	0	0	0	0	21,503	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	27,872	0	27,872	8							
	B. Health Care and Programs													
9	Medical Director	0	0	2,093	0	0	0	0	0	0	0	0	2,093	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	284,528	0	0	0	0	0	0	0	0	0	284,528	10a
11	Activities	0	0	937	0	0	0	0	0	0	0	0	937	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,532	0	0	0	0	0	0	0	0	1,532	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	284,528	4,562	0	289,090	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	(2,043)	(174,302)	13,208	0	0	0	0	0	0	0	0	(163,137)	19
20	Fees, Subscriptions & Promotions	(18,654)	0	8,596	0	0	0	0	0	0	0	0	(10,058)	20
21	Clerical & General Office Expenses	0	0	265,281	0	0	0	0	0	0	0	0	265,281	21
22	Employee Benefits & Payroll Taxes	0	0	34,832	0	0	0	0	0	0	0	0	34,832	22
23	Inservice Training & Education	0	0	1,091	0	0	0	0	0	0	0	0	1,091	23
24	Travel and Seminar	0	0	9,797	0	0	0	0	0	0	0	0	9,797	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	11,639	0	0	0	0	0	0	0	0	11,639	26
27	Other (specify):*	(64)	0	0	0	0	0	0	0	0	0	0	(64)	27
28	TOTAL General Administration	(20,761)	(174,302)	344,444	0	149,381	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,761)	110,226	376,878	0	466,343	29							

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Carlinville# 0048850

Report Period Beginning:

01/01/2009 Ending:

Summary B

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	173,959	0	10,242	0	0	0	0	0	0	0	184,201	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,372)	41,052	0	359	0	0	0	0	0	0	0	39,039	32
33	Real Estate Taxes	0	41,701	0	0	0	0	0	0	0	0	0	41,701	33
34	Rent-Facility & Grounds	0	(473,040)	0	6,701	0	0	0	0	0	0	0	(466,339)	34
35	Rent-Equipment & Vehicles	0	0	0	1,779	0	0	0	0	0	0	0	1,779	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,372)	(216,328)	0	19,081	0	(199,619)	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)	(23,133)	(106,102)	376,878	19,081	0	0	0	0	0	0	0	266,724	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>284,528</u>	<u>284,528</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>174,302</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(174,302)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>473,040</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(473,040)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>41,701</u>	<u>41,701</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>37,994</u>	<u>37,994</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>173,959</u>	<u>173,959</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>3,058</u>	<u>3,058</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>647,342</u>			\$ <u>541,240</u>	\$ * <u>(106,102)</u>	14

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

Facility Name & ID Number

Heritage Manor-Carlinville

0048850

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$	\$ 4,211	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					2,157	19
20	V	6 Maintenance					21,503	20
21	V	7 Other					0	21
22	V	9 Medical Director					2,093	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					937	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,532	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					13,208	31
32	V	20 Fees, Subscription, Promotions					8,596	32
33	V	21 Clerical & General Office Expenses					265,281	33
34	V	22 Employee Benefits & Payroll Taxes					34,832	34
35	V	23 Inservice Training & Education					1,091	35
36	V	24 Travel and Seminar					9,797	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					11,639	38
39	Total		\$			\$	0	\$ * 376,878 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						10,242	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						359	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						6,701	20	
21	V	35 Rent-Equipment & Vehicles						1,779	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	\$ *	19,081	39

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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-Carlinville# 0048850

Report Period Beginning:

01/01/2009Ending: 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	108	\$ 4,211	1
2	2	Food Purchase	Beds	2,634	25	29	0	108	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	108	0	3
4	4	Laundry	Beds	2,634	25	0	0	108	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	108	2,157	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	108	21,503	6
7	7	Other	Beds	2,634	25	0	0	108	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	108	2,093	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	108	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	108	937	10
11	12	Social Service	Beds	2,634	25	0	0	108	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	108	1,532	12
13	14	Program Transportation	Beds	2,634	25	0	0	108	0	13
14	15	Other	Beds	2,634	25	0	0	108	0	14
15	17	Administrative	Beds	2,634	25	0	0	108	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	108	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	108	13,208	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	108	8,596	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	108	265,281	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	108	34,832	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	108	1,091	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	108	9,797	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	108	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	108	11,639	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 376,878	25

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	25	\$	108	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	108	10,242	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		108		3
4	32	Interest	Beds	2,634	25	8,747	108	359	4
5	33	Real Estate Taxes	Beds	2,634	25		108		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	108	6,701	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	108	1,779	7
8	36	Other	Beds	2,634	25		108		8
9	38	Medically Nec Transportation	Beds	2,634	25		108		9
10	39	Ancillary Service Centers	Beds	2,634	25		108		10
11	40	Barber and Beauty Shops	Beds	2,634	25		108		11
12	41	Coffee and Gift Shops	Beds	2,634	25		108		12
13	42	Other	Beds	2,634	25		108		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	\$	\$ 19,081	25

Facility Name & ID Number

Heritage Manor-Carlinville

0048850

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			\$	\$ 848,729	03/11	variable	\$ 35,966	1							
2	Bank of America		xx	Loan Fees							3,058	2							
3	Alpha Community		xx	Van				22,130			2,028	3							
4												4							
5												5							
Working Capital																			
6	Bank of America		xx	Accounts Receivable							12,676	6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$ 870,859			\$ 53,728	9							
B. Non-Facility Related*																			
10	Interest Income										(2,372)	10							
11	Allocated Corporate										359	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (2,013)	14							
15	TOTALS (line 9+line14)						\$	\$ 870,859			\$ 51,715	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,527 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>32,017</u>	1
2					2
3	TOTALS			\$ 32,017	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	108			\$ 3,265,145	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	Heritage Manor Sign		1996	2,176					9
10	Architect Fees		1996	2,387					10
11	Laundry Room Electrical Repair		1996	3,019					11
12									12
13									13
14	Special Care Unit -- Remodel		1997	30,884					14
15									15
16	Remodel-- Alzheimer Wing		1998	78,813					16
17	A/C Unit		1998	950					17
18	Life Safety Improvements		1998	7,351					18
19	Shower Room Remodel		1998	2,811					19
20	Roof Replacement		1998	92,246					20
21									21
22	Door Alarm		1999	2,317					22
23	Smoke Damperer		1999	498					23
24	Water System		1999	8,115					24
25	Interior Painting--Material and Labor		1999	6,892					25
26	Shower Room Remodel		1999	2,453					26
27	Water Heater		1999	4,253					27
28									28
29									29
30									30
31									31
32									32
33									33
34	C/O Allocation						10,242	10,242	34
35	Book Depreciation				132,482		132,482		1,310,763
36									36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Carlinville# 0048850

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	Water Softener	2000	\$ 3,802	\$		\$	\$	\$	37
38	Shower room Remodel ---Material and Labor	2000	3,608						38
39	A/C Rooftop Unit	2000	12,490						39
40	Pipe --Hallway Floor	2000	1,920						40
41									41
42	Electric Heater	2001	4,700						42
43									43
44	A/C Rooftop Unit-(remove)	2002	(12,490)						44
45	Heat / Cool Unit	2002	8,969						45
46	Floor Coverings	2002	6,638						46
47	Roof top unit	2002	4,995						47
48	Roof top unit	2002	2,918						48
49									49
50	Floor coverings	2003	10,318						50
51	Resurface parking lot	2003	25,786						51
52	A/C unit	2003	11,167						52
53	Dishwasher	2003	3,880						53
54	Boiler	2003	1,978						54
55	Backflow unit	2003	740						55
56	Heat / Cool Unit	2003	5,607						56
57									57
58	Hot Water Pump	2004	750						58
59	Heat / Cool Unit	2004	4,485						59
60	Booster Heater	2004	2,261						60
61	Door Closer	2004	578						61
62	A/C Unit	2004	1,101						62
63	Roof top unit	2004	3,504						63
64	Electric Heater	2004	13,454						64
65	Secure Care System	2004	3,053						65
66	Ansul System	2004	1,685						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,638,207	\$ 132,482		\$ 142,724	\$ 10,242	\$ 1,310,763	70

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

Facility Name & ID Number Heritage Manor-Carlinville# 0048850

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 12A, Carried Forward		\$ 3,638,207	\$ 132,482		\$ 142,724	\$ 10,242	\$ 1,310,763	1
2	Window Replacement	2005	371						2
3	HVAC	2005	10,165						3
4	Rooftop A/C	2005	8,997						4
5	Water Storage Tank	2005	4,456						5
6	Rooftop Heater	2005	3,425						6
7									7
8	Sidewalk	2006	630						8
9	Parking Lot Sealer	2006	2,385						9
10	Window Replacement	2006	1,638						10
11	Resident room remodel -- paint, wall coverings	2006	3,390						11
12	Smoke detectors	2006	1,644						12
13									13
14	Resident room remodel -- paint, wall coverings	2007	4,207						14
15	Corridor Rehab -- Paint/Wallpaper	2007	22,058						15
16	HVAC	2007	9,819						16
17	Fire Alarm	2007	2,900						17
18	Rosedale Corridor Rehab-- Paint/ Wallpaper	2007	4,041						18
19	Sprinkler System	2007	3,398						19
20	Heat Detector	2007							20
21	Landscaping	2007							21
22	Rosedale Resident room Rehab -- Paint/Wallpaper	2007	26,384						22
23	Rooftop A/C	2007	4,417						23
24	Kitchen Repairs	2007	1,550						24
25	Asbestos Sample	2007							25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,754,082	\$ 132,482		\$ 142,724	\$ 10,242	\$ 1,310,763	34

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

Facility Name & ID Number Heritage Manor-Carlinville# 0048850

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		\$ 3,754,082	\$ 132,482		\$ 142,724	\$ 10,242	\$ 1,310,763	1
2	PTAC Units	2008	7,980						2
3	Nurse call/Phone System	2008	157,428						3
4	Kitchen Water Heater	2008	2,600						4
5	Rosedale wing room remodel-- paint/flooring	2008	15,673						5
6	Kitchen plumbing	2008	3,130						6
7	Sprinkler	2008	5,972						7
8	Legacy Unit Remodel--paint/flooring	2008	37,068						8
9	Fire Alarm	2008	47,279						9
10									10
11	Sewer Line	2009	6,355						11
12	Therapy Renovation: paint, electrical, flooring	2009	76,398						12
13	Kitchen pipe	2009	2,700						13
14	Shower	2009	5,080						14
15	Door Alarms	2009	42,322						15
16	Nurse call/Phone System	2009	35,992						16
17	Fire Alarm	2009	15,451						17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,215,510	\$ 132,482		\$ 142,724	\$ 10,242	\$ 1,310,763	34

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

Facility Name & ID Number Heritage Manor-Carlinville

0048850

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	\$ 639,558	\$ 41,477	\$ 41,477	\$		\$ 485,209	71
72	Current Year Purchases	49,955						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 689,513	\$ 41,477	\$ 41,477	\$		\$ 485,209	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)	\$ 4,937,040	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 173,959	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 184,201	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,242	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,795,972	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: \$ 11,736 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.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

* 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		3,848		3,848
3	Classroom Wages (a)				
4	Clinical Wages (b)		9,888		9,888
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 13,736	\$	\$ 13,736
10	SUM OF line 9, col. 1 and 2 (e)	\$	13,736		

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	\$		\$ 130,030	\$		\$ 130,030	1
2	Licensed Speech and Language Development Therapist		hrs			38,022			38,022	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			130,186	384		130,570	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				280,577		280,577	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					10,179			10,179	13
14	TOTAL			\$		\$ 308,417	\$ 280,961		\$ 589,378	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-Carlinville# 0048850Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 423	\$	1
2	Cash-Patient Deposits	13,014		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	342,153		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,527		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,081,823)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,706,706)	\$	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)	\$ (1,706,706)	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 91,877	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,014		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	190,216		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,749		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)	\$ 318,856	\$	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)	\$ 318,856	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,025,562)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,706,706)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,549,556)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,549,556)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(476,006)	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)	\$ (476,006)	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)	\$ (2,025,562)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Carlinville# 0048850Report 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,875,801	1
2	Discounts and Allowances for all Levels	(1,372,569)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,503,232	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,037,658	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,037,658	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	3,198	12
13	Barber and Beauty Care	10,452	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	493,282	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	14,788	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 521,720	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,372	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,372	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)	\$ 4,064,982	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	811,268	31
32	Health Care	2,142,088	32
33	General Administration	1,082,477	33
B. Capital Expense			
34	Ownership	497,452	34
C. Ancillary Expense			
35	Special Cost Centers	7,703	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,540,988	40
41	Income before Income Taxes (line 30 minus line 40)**	(476,006)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (476,006)	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-Carlinville**

0048850

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	1,520	1,544	\$ 47,063	\$ 30.48	1
2	Assistant Director of Nursing	210	225	5,202	23.12	2
3	Registered Nurses	2,596	2,882	86,554	30.03	3
4	Licensed Practical Nurses	17,176	18,874	421,292	22.32	4
5	CNAs & Orderlies	60,586	65,431	703,517	10.75	5
6	CNA Trainees	1,000	1,000	9,888	9.89	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,433	3,648	59,268	16.25	8
9	Activity Director					9
10	Activity Assistants	4,634	5,366	52,491	9.78	10
11	Social Service Workers	1,860	1,950	30,704	15.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,297	17,472	175,151	10.02	15
16	Dishwashers					16
17	Maintenance Workers	4,191	4,521	62,809	13.89	17
18	Housekeepers	9,808	10,214	112,076	10.97	18
19	Laundry	5,104	5,254	48,145	9.16	19
20	Administrator	1,900	2,080	60,367	29.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,056	9,806	151,150	15.41	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)	139,371	150,267	\$ 2,025,677 *	\$ 13.48	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	3,000		36
37	Medical Records Consultant	8,428		37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,240		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	3,043		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 17,711		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
<u>Kelly Hungerford</u>				\$ <u>60,367</u>	<u>Workers' Compensation Insurance</u>	\$ <u>95,117</u>	<u>IDPH License Fee</u>	\$ <u>0</u>	
					<u>Unemployment Compensation Insurance</u>		<u>Advertising: Employee Recruitment</u>	<u>4,927</u>	
					<u>FICA Taxes</u>	<u>173,453</u>	<u>Health Care Worker Background Check</u>		
					<u>Employee Health Insurance</u>	<u>210,813</u>	(Indicate # of checks performed)	<u>1,050</u>	
					<u>Employee Meals</u>		<u>Central Office</u>	<u>8,596</u>	
					<u>Illinois Municipal Retirement Fund (IMRF)*</u>				
						<u>0</u>		<u>9,772</u>	
TOTAL (agree to Schedule V, line 17, col. 1)					<u>Other Benefits</u>	<u>12,944</u>	<u>Dues & Subscriptions</u>	<u>9,385</u>	
(List each licensed administrator separately.)				\$ <u>60,367</u>	<u>Central Office Allocation</u>	<u>34,832</u>	<u>License & Fees</u>	<u>2,720</u>	
B. Administrative - Other									
Description			Amount				<u>Less: Public Relations Expense</u>	<u>(9,772)</u>	
			\$				<u>Non-allowable advertising</u>	<u>(1,198)</u>	
							<u>Yellow page advertising</u>	<u>(0)</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$		TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>527,159</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>25,480</u>	
(Attach a copy of any management service agreement)									
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
<u>Heritage Operations Group</u>	<u>Mgt Fee</u>		\$ <u>174,302</u>			\$	<u>Out-of-State Travel</u>	\$	
			<u>0</u>						
							<u>In-State Travel</u>		
								<u>9,318</u>	
								<u>397</u>	
							<u>Seminar Expense</u>	<u>4,098</u>	
			<u>0</u>					<u>0</u>	
			<u>2,043</u>				<u>Central Office</u>	<u>9,797</u>	
			<u>0</u>						
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>176,345</u>	TOTAL		\$	<u>Entertainment Expense</u>	()	
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ <u>23,610</u>	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor-Carlinville# 0048850Report 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 Carlinville 41509 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,130
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.