

		FOR BHF USE					

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

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

<p><b>I. IDPH License ID Number:</b> <u>0048124</u></p> <p><b>Facility Name:</b> <u>Heritage Manor-El Paso</u></p> <p><b>Address:</b> <u>555 E. Clay Street</u> <u>El Paso</u> <u>61738</u>        Number City Zip Code</p> <p><b>County:</b> <u>Woodford</u></p> <p><b>Telephone Number:</b> <u>( 309 ) 527-6240</u> Fax # ( )</p> <p><b>HFS ID Number:</b> <u>20-3903447001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>07/2006</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</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	<b>IRS Exemption Code</b> _____	<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><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Craig L. Ater</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Exec V.P. &amp; CFO</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Craig L. Ater</u> <u>Exec V.P. &amp; CFO</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Heritage Operations Group, LLC.</u></td> <td></td> </tr> <tr> <td>(Telephone) ( ) Fax # ( )</td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Craig L. Ater</u>			(Title) <u>Exec V.P. &amp; CFO</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Craig L. Ater</u> <u>Exec V.P. &amp; CFO</u>		(Firm Name & Address) <u>Heritage Operations Group, LLC.</u>		(Telephone) ( ) Fax # ( )	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(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-El Paso

# 0048124 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	65	Skilled (SNF)	65	23,725	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	65	TOTALS	65	23,725	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	11,784	9,226	1,305	22,315	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,784	9,226	1,305	22,315	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.06%

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 07/2006

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 1,305

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-El Paso # 0048124 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	191,244	21,921		213,165		213,165	2,535	215,700		1
2	Food Purchase		153,051		153,051		153,051	1	153,052		2
3	Housekeeping	65,807	(3,302)		62,505		62,505		62,505		3
4	Laundry	66,062	12,589		78,651		78,651		78,651		4
5	Heat and Other Utilities			84,629	84,629		84,629	1,298	85,927		5
6	Maintenance	45,502	43,928	44,574	134,004		134,004	12,941	146,945		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	368,615	228,187	129,203	726,005		726,005	16,775	742,780		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,560	7,560		7,560	1,260	8,820		9
10	Nursing and Medical Records	1,092,495	83,786	118,072	1,294,353		1,294,353		1,294,353		10
10a	Therapy		143,794	249,052	392,846	(153,779)	239,067	145,438	384,505		10a
11	Activities	106,290	3,114		109,404		109,404	564	109,968		11
12	Social Services	29,385	14	1,802	31,201		31,201		31,201		12
13	CNA Training	9,388	857		10,245		10,245	922	11,167		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,237,558	231,565	376,486	1,845,609	(153,779)	1,691,830	148,184	1,840,014		16
	<b>C. General Administration</b>										
17	Administrative	66,900			66,900		66,900		66,900		17
18	Directors Fees										18
19	Professional Services			177,120	177,120		177,120	(169,171)	7,949		19
20	Dues, Fees, Subscriptions & Promotions			72,413	72,413	(35,588)	36,825	(11,191)	25,634		20
21	Clerical & General Office Expenses	92,316	26,052	8,857	127,225		127,225	159,660	286,885		21
22	Employee Benefits & Payroll Taxes			384,773	384,773		384,773	20,964	405,737		22
23	Inservice Training & Education			4,046	4,046		4,046	656	4,702		23
24	Travel and Seminar			3,201	3,201		3,201	5,896	9,097		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			31,785	31,785		31,785	7,005	38,790		26
27	Other (specify):*			7,024	7,024		7,024	(6,756)	268		27
28	<b>TOTAL General Administration</b>	159,216	26,052	689,219	874,487	(35,588)	838,899	7,063	845,962		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,765,389	485,804	1,194,908	3,446,101	(189,367)	3,256,734	172,022	3,428,756		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 &amp; ID Number

Heritage Manor-El Paso

#0048124

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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							121,633	121,633			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,628	7,628		7,628	44,707	52,335			32
33	Real Estate Taxes							77,455	77,455			33
34	Rent-Facility & Grounds			284,700	284,700		284,700	(288,893)	(4,193)			34
35	Rent-Equipment & Vehicles			7,445	7,445		7,445	1,071	8,516			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			299,773	299,773		299,773	(44,027)	255,746			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					153,779	153,779		153,779			39
40	Barber and Beauty Shops			7,197	7,197		7,197		7,197			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					35,588	35,588		35,588			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			7,197	7,197	189,367	196,564		196,564			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,765,389	485,804	1,501,878	3,753,071		3,753,071	127,995	3,881,066			45

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



Heritage Manor-El Paso

ID# 0048124

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		(312)	20	17
18				18
19			24	19
20		(756)	27	20
21				21
22		(2,270)	19	22
23				23
24		(6,000)	27	24
25		(16,053)	20	25
26				26
27				27
28				28
29		0	33	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(25,391)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-El Paso# 0048124

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	2,535	0	0	0	0	0	0	0	0	2,535	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	1,298	0	0	0	0	0	0	0	0	1,298	5
6	Maintenance	0	0	12,941	0	0	0	0	0	0	0	0	12,941	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>16,775</b>	<b>0</b>	<b>16,775</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	1,260	0	0	0	0	0	0	0	0	1,260	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	145,438	0	0	0	0	0	0	0	0	0	145,438	10a
11	Activities	0	0	564	0	0	0	0	0	0	0	0	564	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	922	0	0	0	0	0	0	0	0	922	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>145,438</b>	<b>2,746</b>	<b>0</b>	<b>148,184</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,270)	(174,850)	7,949	0	0	0	0	0	0	0	0	(169,171)	19
20	Fees, Subscriptions & Promotions	(16,365)	0	5,174	0	0	0	0	0	0	0	0	(11,191)	20
21	Clerical & General Office Expenses	0	0	159,660	0	0	0	0	0	0	0	0	159,660	21
22	Employee Benefits & Payroll Taxes	0	0	20,964	0	0	0	0	0	0	0	0	20,964	22
23	Inservice Training & Education	0	0	656	0	0	0	0	0	0	0	0	656	23
24	Travel and Seminar	0	0	5,896	0	0	0	0	0	0	0	0	5,896	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	7,005	0	0	0	0	0	0	0	0	7,005	26
27	Other (specify):*	(6,756)	0	0	0	0	0	0	0	0	0	0	(6,756)	27
28	<b>TOTAL General Administration</b>	<b>(25,391)</b>	<b>(174,850)</b>	<b>207,304</b>	<b>0</b>	<b>7,063</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(25,391)</b>	<b>(29,412)</b>	<b>226,825</b>	<b>0</b>	<b>172,022</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-El Paso# 0048124

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	115,469	0	6,164	0	0	0	0	0	0	0	121,633	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,973)	46,464	0	216	0	0	0	0	0	0	0	44,707	32
33	Real Estate Taxes	0	77,455	0	0	0	0	0	0	0	0	0	77,455	33
34	Rent-Facility & Grounds	(8,226)	(284,700)	0	4,033	0	0	0	0	0	0	0	(288,893)	34
35	Rent-Equipment & Vehicles	0	0	0	1,071	0	0	0	0	0	0	0	1,071	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(10,199)</b>	<b>(45,312)</b>	<b>0</b>	<b>11,484</b>	<b>0</b>	<b>(44,027)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(35,590)	(74,724)	226,825	11,484	0	0	0	0	0	0	0	127,995	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>145,438</u>	<u>145,438</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>174,850</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(174,850)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>284,700</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(284,700)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>77,455</u>	<u>77,455</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>40,602</u>	<u>40,602</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>115,469</u>	<u>115,469</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>5,862</u>	<u>5,862</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>459,550</u>			\$ <u>384,826</u>	\$ * <u>(74,724)</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%	\$	\$ 2,535	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					1,298	19
20	V	6 Maintenance					12,941	20
21	V	7 Other					0	21
22	V	9 Medical Director					1,260	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					564	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					922	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					7,949	31
32	V	20 Fees, Subscription, Promotions					5,174	32
33	V	21 Clerical & General Office Expenses					159,660	33
34	V	22 Employee Benefits & Payroll Taxes					20,964	34
35	V	23 Inservice Training & Education					656	35
36	V	24 Travel and Seminar					5,896	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					7,005	38
39	Total		\$			\$	0	\$ * 226,825 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	0 15
16	V	30 Depreciation						6,164 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						216 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						4,033 20
21	V	35 Rent-Equipment & Vehicles						1,071 21
22	V	36 Other						0 22
23	V	38 Medically Nec Transportation						0 23
24	V	39 Ancillary Service Centers						0 24
25	V	40 Barber and Beauty Shops						0 25
26	V	41 Coffee and Gift Shops						0 26
27	V	42 Other						0 27
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$	\$	0 \$ * 11,484 39

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

Facility Name &amp; ID Number

Heritage Manor-El Paso

# 0048124

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-El Paso

# 0048124

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 102,708	\$ 102,349	65	\$ 2,535	1
2	2	Food Purchase	Beds	2,634	25	29	0	65	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	65	0	3
4	4	Laundry	Beds	2,634	25	0	0	65	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	65	1,298	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	65	12,941	6
7	7	Other	Beds	2,634	25	0	0	65	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	65	1,260	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	65	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	65	564	10
11	12	Social Service	Beds	2,634	25	0	0	65	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	65	922	12
13	14	Program Transportation	Beds	2,634	25	0	0	65	0	13
14	15	Other	Beds	2,634	25	0	0	65	0	14
15	17	Administrative	Beds	2,634	25	0	0	65	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	65	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	65	7,949	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	65	5,174	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	65	159,660	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	65	20,964	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	65	656	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	65	5,896	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	65	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	65	7,005	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 226,825	25

Facility Name & ID Number Heritage Manor-El Paso

# 0048124

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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	\$	65	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	65	6,164	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		65		3
4	32	Interest	Beds	2,634	25	8,747	65	216	4
5	33	Real Estate Taxes	Beds	2,634	25		65		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	65	4,033	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	65	1,071	7
8	36	Other	Beds	2,634	25		65		8
9	38	Medically Nec Transportation	Beds	2,634	25		65		9
10	39	Ancillary Service Centers	Beds	2,634	25		65		10
11	40	Barber and Beauty Shops	Beds	2,634	25		65		11
12	41	Coffee and Gift Shops	Beds	2,634	25		65		12
13	42	Other	Beds	2,634	25		65		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	\$	\$ 11,484	25

Facility Name & ID Number

Heritage Manor-El Paso

# 0048124

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Bank of America		xx	Mortgage			\$	\$ 565,019	03/11	variable	\$ 40,602	1							
2	Bank of America		xx	Loan Fees							5,862	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Bank of America		xx	Accounts Receivable							7,628	6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$	\$ 565,019			\$ 54,092	9							
<b>B. Non-Facility Related*</b>																			
10	Interest Income										(1,973)	10							
11	Allocated Corporate										216	11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (1,757)	14							
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 565,019			\$ 52,335	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.)		\$	<b>76,376</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>76,376</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>76,376</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>77,038</b>		8
	2005	<b>82,833</b>		9
	2006	<b>65,686</b>		10
	2007	<b>75,348</b>		11
	2008	<b>76,376</b>		12
	<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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



Facility Name & ID Number Heritage Manor-El Paso

# 0048124

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 8,500 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>22,678</u>	1
2					2
3	TOTALS			\$ <u>22,678</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	65			\$ 988,669	\$		\$	\$	\$
5				702,618					
6									
7									
8									
<b>Improvement Type**</b>									
9	1987 Improvements	1987		12,921					
10	1989 Improvements	1989		2,285					
11	1989 Improvements	1989							
12	1990 Improvements	1990		28,354					
13	1991 Improvements	1991		405					
14	1992 Improvements	1992							
15	1993 Improvements	1993		37,061					
16	1994 Improvements	1994		7,004					
17	1995 Improvements	1995		3,992					
18	A/C Frames	1996		3,695					
19	Dinning Room A/C & Heat Unit	1996		12,007					
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34							6,164	6,164	
35					80,564		80,564		1,029,643
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-El Paso# 0048124

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	Alarm Wiring	1997	\$ 1,733	\$		\$	\$	\$	37
38	Access Doors	1997	1,075						38
39	Sinks and Faucets	1997	2,738						39
40	Walk in Cooler	1997	1,500						40
41	Motor--Boiler	1997	1,634						41
42									42
43	Kitchen Outlets and Kitchenette Addition	1998	4,389						43
44									44
45	Sprinkler Replacement	1999	4,569						45
46	Air conditioning Units	1999	6,820						46
47									47
48	Carpet Dayroom	2000	1,796						48
49									49
50	Air Handler-- Dinning Room	2001	5,490						50
51	Code Alert	2001	3,833						51
52	Condensing Unit	2001	2,565						52
53	A/C Unit	2001	701						53
54	Walk-in Cooler	2001	12,696						54
55									55
56	Walk in cooler	2002	1,650						56
57	Compressor	2002	4,178						57
58	A/C Unit	2002	1,159						58
59	Exterior Door	2002	2,603						59
60	A/C Unit	2002	5,901						60
61	Heat/Cool Unit	2002	2,154						61
62	Furnace	2002	1,975						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,870,170	\$ 80,564		\$ 86,728	\$ 6,164	\$ 1,029,643	70

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

Facility Name & ID Number Heritage Manor-El Paso# 0048124

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,870,170	\$ 80,564		\$ 86,728	\$ 6,164	\$ 1,029,643	1
2	Floor Coverings	2003	37,896						2
3	Dampers	2003	1,660						3
4	Fencing	2003	1,656						4
5	A/C unit	2003	1,738						5
6	Furnace	2003	2,450						6
7									7
8	A/C unit	2004	524						8
9	Garbage Disposal	2004	951						9
10	Water Heater	2004	3,252						10
11									11
12	Ansul System Upgrade	2005	800						12
13	A/C unit	2005	2,140						13
14	Remodel new resident room	2005	26,097						14
15	Exterior Remodel	2005	5,048						15
16	Air handler	2005	2,670						16
17	Water Service	2005	6,247						17
18									18
19	Nurse Call	2006	3,017						19
20	Sidewalk	2006	1,824						20
21	Roof repair	2006	10,751						21
22	Door Alarm	2006	13,522						22
23	A/C unit	2006	2,087						23
24	Furnace	2006	18,500						24
25	Parking Lot sealer	2006	2,353						25
26	Window Replacement	2006	60,015						26
27	Dinning room --paint and remodel	2006	8,217						27
28	Water valve	2006	2,701						28
29	Two Bed expansion -- material/labor	2006	24,784						29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,111,070	\$ 80,564		\$ 86,728	\$ 6,164	\$ 1,029,643	34

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

Facility Name & ID Number Heritage Manor-El Paso# 0048124

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	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,111,070	\$ 80,564		\$ 86,728	\$ 6,164	\$ 1,029,643	1
2	Dinning room --paint and remodel	2007	14,189						2
3	Window Replacement	2007	20,175						3
4	Doors	2007	899						4
5	Flood Light	2007	837						5
6	Sprinkler heads	2007	1,314						6
7	Smoke Wall	2007	1,974						7
8	Air Handler	2007	5,690						8
9	A/C	2007	5,959						9
10	Freidrich A/C	2007	2,348						10
11	Parking Lot resurface	2007	1,200						11
12	Dishroom Flooring	2007	290						12
13									13
14	HVAC Units	2008	2,338						14
15	Nurse Call & Phone system w/ Cabling	2008	153,984						15
16	Kitchen Flooring	2008	11,403						16
17	Wireless equipment for Nurse Call	2008	9,874						17
18									18
19	Plumbing Waste Line	2009	4,754						19
20	Parking Lot resurface	2009	25,727						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	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,374,025	\$ 80,564		\$ 86,728	\$ 6,164	\$ 1,029,643	34

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

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	\$ 560,049	\$ 34,905	\$ 34,905	\$		\$ 537,965	71
72	Current Year Purchases	23,664						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 583,713	\$ 34,905	\$ 34,905	\$		\$ 537,965	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 Van	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)	\$ 3,042,231	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 115,469	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 121,633	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,164	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,567,608	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: \$ 7,445 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		857		857
3	Classroom Wages (a)				
4	Clinical Wages (b)		9,388		9,388
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 10,245	\$	\$ 10,245
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	10,245		

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 110,563	\$		\$ 110,563	1
2	Licensed Speech and Language Development Therapist		hrs			3,178			3,178	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			124,958	368		125,326	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				143,426		143,426	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					10,353			10,353	13
14	<b>TOTAL</b>			\$		\$ 249,052	\$ 143,794		\$ 392,846	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-El Paso**

# **0048124**

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 9,271	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	233,085		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,025		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	77,093		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 339,474	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 339,474	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 101,182	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	134,581		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,810		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 256,573	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 256,573	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 82,901	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 339,474	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,037</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>3,037</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>79,864</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>79,864</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>82,901</b>	<b>24</b> *

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

Facility Name & ID Number Heritage Manor-El Paso# 0048124Report Period Beginning: 01/01/2009Ending: 12/31/2009

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,631,882	1
2	Discounts and Allowances for all Levels	(816,300)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,815,582</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	759,595	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 759,595</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	258	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,226	16
17	Sale of Drugs	244,911	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,302	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 255,697</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,973	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,973</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Other</b>	88	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 88</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,832,935</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	726,005	31
32	Health Care	1,845,609	32
33	General Administration	874,487	33
<b>B. Capital Expense</b>			
34	Ownership	299,773	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	7,197	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,753,071</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>79,864</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 79,864</b>	<b>43</b>

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

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

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

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

Facility Name & ID Number **Heritage Manor-El Paso**

# **0048124**

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	1,818	2,100	\$ 57,497	\$ 27.38	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,303	8,691	238,358	27.43	3
4	Licensed Practical Nurses	8,996	10,084	235,502	23.35	4
5	CNAs & Orderlies	44,408	46,863	561,138	11.97	5
6	CNA Trainees	900	900	9,388	10.43	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	9,091	9,890	106,290	10.75	10
11	Social Service Workers	1,996	2,176	29,385	13.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,686	17,126	191,244	11.17	15
16	Dishwashers					16
17	Maintenance Workers	3,732	3,972	45,502	11.46	17
18	Housekeepers	8,208	8,855	65,807	7.43	18
19	Laundry	4,278	5,148	66,062	12.83	19
20	Administrator	1,900	2,080	66,900	32.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,603	6,189	92,316	14.92	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)	114,919	124,074	\$ 1,765,389 *	\$ 14.23	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	7,560		36
37	Medical Records Consultant	3,127		37
38	Nurse Consultant			38
39	Pharmacist Consultant	1,890		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	1,802		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 14,379		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	863	\$ 34,538	50
51	Licensed Practical Nurses	492	17,211	51
52	Certified Nurse Assistants/Aides	2,279	56,984	52
53	TOTAL (lines 50 - 52)	3,635	\$ 108,733	53





Facility Name & ID Number Heritage Manor-El Paso# 0048124Report 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 ElPaso 38365 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 35,588  
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.