

Facility Name & ID Number Heritage Manor-Elgin

0048132 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	94	Skilled (SNF)	94	34,310	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	94	TOTALS	94	34,310	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	21,963	2,805	3,964	28,732	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,963	2,805	3,964	28,732	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.74%

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 3,964

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

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	258,312	23,143		281,455		281,455	3,665	285,120		1
2	Food Purchase		169,724		169,724		169,724	1	169,725		2
3	Housekeeping	100,878	23,227		124,105		124,105		124,105		3
4	Laundry	47,723	28,475		76,198		76,198		76,198		4
5	Heat and Other Utilities			114,342	114,342		114,342	1,877	116,219		5
6	Maintenance	79,135	60,912	62,632	202,679		202,679	18,715	221,394		6
7	Other (specify):*										7
8	TOTAL General Services	486,048	305,481	176,974	968,503		968,503	24,258	992,761		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000	1,822	7,822		9
10	Nursing and Medical Records	1,775,083	123,700	17,429	1,916,212		1,916,212		1,916,212		10
10a	Therapy		193,433	746,966	940,399	(197,060)	743,339	243,265	986,604		10a
11	Activities	74,478	4,374		78,852		78,852	816	79,668		11
12	Social Services	33,027	46	3,620	36,693		36,693		36,693		12
13	CNA Training	1,936	2,815		4,751		4,751	1,333	6,084		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,884,524	324,368	774,015	2,982,907	(197,060)	2,785,847	247,236	3,033,083		16
	C. General Administration										
17	Administrative	103,312			103,312		103,312		103,312		17
18	Directors Fees										18
19	Professional Services			241,441	241,441		241,441	(229,946)	11,495		19
20	Dues, Fees, Subscriptions & Promotions			91,567	91,567	(51,465)	40,102	(24,812)	15,290		20
21	Clerical & General Office Expenses	213,529	43,319	9,714	266,562		266,562	230,892	497,454		21
22	Employee Benefits & Payroll Taxes			405,802	405,802		405,802	30,317	436,119		22
23	Inservice Training & Education			4,569	4,569		4,569	949	5,518		23
24	Travel and Seminar			9,216	9,216		9,216	8,527	17,743		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,646	64,646		64,646	10,130	74,776		26
27	Other (specify):*			50,550	50,550		50,550	(50,550)			27
28	TOTAL General Administration	316,841	43,319	877,505	1,237,665	(51,465)	1,186,200	(24,493)	1,161,707		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,687,413	673,168	1,828,494	5,189,075	(248,525)	4,940,550	247,001	5,187,551		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-Elgin

#0048132

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							140,545	140,545			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,030	11,030		11,030	47,592	58,622			32
33	Real Estate Taxes							50,366	50,366			33
34	Rent-Facility & Grounds			411,720	411,720		411,720	(405,888)	5,832			34
35	Rent-Equipment & Vehicles			1,976	1,976		1,976	1,549	3,525			35
36	Other (specify):*											36
37	TOTAL Ownership			424,726	424,726		424,726	(165,836)	258,890			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers						197,060	197,060	197,060			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee						51,465	51,465	51,465			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers						248,525	248,525	248,525			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,687,413	673,168	2,253,220	5,613,801		5,613,801	81,165	5,694,966			45

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

Facility Name & ID Number Heritage Manor-Elgin

0048132

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(6,078)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		23		16
17	Non-Care Related Fees	(451)	20		17
18	Fines and Penalties				18
19	Entertainment		24		19
20	Contributions	(150)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(27,264)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,400)	27		24
25	Fund Raising, Advertising and Promotional	(31,843)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (116,186)		\$	30

BHF USE ONLY					
48		49		50	
				51	
				52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	197,351		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 197,351		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 81,165		37

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

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

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

Heritage Manor-Elgin

ID# 0048132

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		(451)	20	17
18				18
19			24	19
20		(150)	27	20
21				21
22		(27,264)	19	22
23				23
24		(50,400)	27	24
25		(31,843)	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		(110,108)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Elgin# 0048132

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,665	0	0	0	0	0	0	0	0	3,665	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	1,877	0	0	0	0	0	0	0	0	1,877	5
6	Maintenance	0	0	18,715	0	0	0	0	0	0	0	0	18,715	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	24,258	0	0	0	0	0	0	0	0	24,258	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,822	0	0	0	0	0	0	0	0	1,822	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	243,265	0	0	0	0	0	0	0	0	0	243,265	10a
11	Activities	0	0	816	0	0	0	0	0	0	0	0	816	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,333	0	0	0	0	0	0	0	0	1,333	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	243,265	3,971	0	0	0	0	0	0	0	0	247,236	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	(27,264)	(214,177)	11,495	0	0	0	0	0	0	0	0	(229,946)	19
20	Fees, Subscriptions & Promotions	(32,294)	0	7,482	0	0	0	0	0	0	0	0	(24,812)	20
21	Clerical & General Office Expenses	0	0	230,892	0	0	0	0	0	0	0	0	230,892	21
22	Employee Benefits & Payroll Taxes	0	0	30,317	0	0	0	0	0	0	0	0	30,317	22
23	Inservice Training & Education	0	0	949	0	0	0	0	0	0	0	0	949	23
24	Travel and Seminar	0	0	8,527	0	0	0	0	0	0	0	0	8,527	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	10,130	0	0	0	0	0	0	0	0	10,130	26
27	Other (specify):*	(50,550)	0	0	0	0	0	0	0	0	0	0	(50,550)	27
28	TOTAL General Administration	(110,108)	(214,177)	299,792	0	0	0	0	0	0	0	0	(24,493)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(110,108)	29,088	328,021	0	0	0	0	0	0	0	0	247,001	29

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Elgin# 0048132

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	131,631	0	8,914	0	0	0	0	0	0	0	140,545	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,078)	53,358	0	312	0	0	0	0	0	0	0	47,592	32
33	Real Estate Taxes	0	50,366	0	0	0	0	0	0	0	0	0	50,366	33
34	Rent-Facility & Grounds	0	(411,720)	0	5,832	0	0	0	0	0	0	0	(405,888)	34
35	Rent-Equipment & Vehicles	0	0	0	1,549	0	0	0	0	0	0	0	1,549	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,078)	(176,365)	0	16,607	0	(165,836)	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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(116,186)	(147,277)	328,021	16,607	0	81,165	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>243,265</u>	<u>243,265</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>214,177</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(214,177)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>411,720</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(411,720)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>50,366</u>	<u>50,366</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>47,033</u>	<u>47,033</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>131,631</u>	<u>131,631</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>6,325</u>	<u>6,325</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 625,897			\$ 478,620	\$ * (147,277)	14

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

Facility Name & ID Number

Heritage Manor-Elgin

0048132

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%	\$	\$	3,665	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						1,877	19	
20	V	6 Maintenance						18,715	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						1,822	22	
23	V	10 Nursing & Medical Records						0	23	
24	V	11 Activities						816	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,333	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						11,495	31	
32	V	20 Fees, Subscription, Promotions						7,482	32	
33	V	21 Clerical & General Office Expenses						230,892	33	
34	V	22 Employee Benefits & Payroll Taxes						30,317	34	
35	V	23 Inservice Training & Education						949	35	
36	V	24 Travel and Seminar						8,527	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						10,130	38	
39	Total		\$			\$	0	\$ *	328,021	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						8,914 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						312 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						5,832 20
21	V	35 Rent-Equipment & Vehicles						1,549 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	\$ * 16,607 39

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

Facility Name & ID Number Heritage Manor-Elgin # 0048132 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-Elgin

0048132

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Heritage Operations Group

Street Address

box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 102,708	\$ 102,349	94	\$ 3,665	1
2	2	Food Purchase	Beds	2,634	25	29	0	94	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	94	0	3
4	4	Laundry	Beds	2,634	25	0	0	94	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	94	1,877	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	94	18,715	6
7	7	Other	Beds	2,634	25	0	0	94	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	94	1,822	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	94	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	94	816	10
11	12	Social Service	Beds	2,634	25	0	0	94	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	94	1,333	12
13	14	Program Transportation	Beds	2,634	25	0	0	94	0	13
14	15	Other	Beds	2,634	25	0	0	94	0	14
15	17	Administrative	Beds	2,634	25	0	0	94	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	94	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	94	11,495	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	94	7,482	18
19	21	Clerical & General Office Expens	Beds	2,634	25	6,469,900	6,230,337	94	230,892	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	94	30,317	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	94	949	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	94	8,527	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	94	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	94	10,130	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 328,021	25

Facility Name & ID Number Heritage Manor-Elgin

0048132

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	25	\$	94	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	94	8,914	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		94		3
4	32	Interest	Beds	2,634	25	8,747	94	312	4
5	33	Real Estate Taxes	Beds	2,634	25		94		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	94	5,832	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	94	1,549	7
8	36	Other	Beds	2,634	25		94		8
9	38	Medically Nec Transportation	Beds	2,634	25		94		9
10	39	Ancillary Service Centers	Beds	2,634	25		94		10
11	40	Barber and Beauty Shops	Beds	2,634	25		94		11
12	41	Coffee and Gift Shops	Beds	2,634	25		94		12
13	42	Other	Beds	2,634	25		94		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	\$		\$ 16,607	25

Facility Name & ID Number

Heritage Manor-Elgin

0048132

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	Name of Lender	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			\$	\$ 697,580	03/11	variable	\$ 47,033	1						
2	Bank of America		xx	Loan Fees							6,325	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Bank of America		xx	Accounts Receivable							11,030	6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$ 697,580			\$ 64,388	9						
B. Non-Facility Related*																		
10	Interest Income										(6,078)	10						
11	Allocated Corporate										312	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (5,766)	14						
15	TOTALS (line 9+line14)						\$	\$ 697,580			\$ 58,622	15						

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	50,366	2
3. Under or (over) accrual (line 2 minus line 1).		\$	50,366	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	50,366	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	49,307	8
	2005	53,167	9
	2006	59,527	10
	2007	49,733	11
	2008	50,366	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>50,366.00</u>	\$ <u>50,366.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Heritage Manor-Elgin

0048132 Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>80,000</u>	1
2					2
3	TOTALS			\$ <u>80,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	94			\$ 720,000	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	1989 Improvements	1989		180,739					
10	1990 Improvements	1990		658,346					
11	1990 Improvements	1990		4,320					
12	1991 Improvements	1991		52,989					
13	1992 Improvements	1992		6,777					
14	1993 Improvements	1993		54,564					
15	1994 Improvements	1994		81,347					
16	1995 Improvements	1995		146,394					
17	Remodel Resident Day Room/Nurses Station	1996		23,749					
18	Interior Rehab	1997		751					
19	Electric Water Heater	1997		3,965					
20	Booster Heater	1997		1,622					
21	Water Heater and Storage Tank	1998		6,485					
22									
23	Water Heater	1999		4,750					
24	Code Alert System	1999		1,570					
25	Resident Room Remodel--Material and Labor	1999		2,571					
26									
27									
28									
29									
30									
31									
32									
33									
34	C/O Allocation						8,914	8,914	
35	Book Depreciation				98,280		98,280		1,317,080
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-Elgin

0048132

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	South Wing Remodel -- Labor / Materials	2000	\$ 14,334	\$		\$	\$	\$	37
38	Door	2000	1,535						38
39	Dry Chemical Extinguisher	2000	1,746						39
40									40
41	Water Heater	2001	4,935						41
42	Valve thermometer	2001	4,520						42
43	A/C Unit	2001	3,319						43
44	Hallway Carpet and Tile Material and Labor	2001	28,843						44
45	Wallpaper	2001	2,390						45
46	Nurse Call System	2001	21,612						46
47									47
48	Hallway and Room Carpet and Tile Material	2002	74,533						48
49	Labor	2002	68,734						49
50	Professional Fees	2002	16,497						50
51	Kitchen Pipe	2002	1,830						51
52	Shower Repairs	2002	5,063						52
53	A/C Unit	2002	5,864						53
54	Bathroom Rehab	2002	750						54
55	Condensor	2002	1,600						55
56	Hallway and Room Carpet and Tile Material --South wing	2002	5,777						56
57									57
58	Hallway and Room Carpet and Tile Material --South wing	2003	92,993						58
59	Exterior Door	2003	320						59
60	Parking Lot Sealer	2003	4,469						60
61	Door Security	2003	2,160						61
62	Ductwork	2003	6,628						62
63	compressor	2003	1,195						63
64	Blower Unit	2003	1,784						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,324,370	\$ 98,280		\$ 107,194	\$ 8,914	\$ 1,317,080	70

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

Facility Name & ID Number Heritage Manor-Elgin

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		\$ 2,324,370	\$ 98,280		\$ 107,194	\$ 8,914	\$ 1,317,080	1
2	Exhaust fan	2005	1,950						2
3	Exterior Doors	2005	2,218						3
4	Compressor	2005	1,608						4
5									5
6	Fire Alarm	2006	1,714						6
7	Parking Lot	2006	2,344						7
8	Remodel Corridor --paint	2006	4,028						8
9	Water Main	2006	3,250						9
10									10
11	Roof	2007	94,451						11
12	Central Corridor paint, tile	2007	49,685						12
13	Plumbing fixtures	2007	2,400						13
14	Rooftop heat/cool unit	2007	5,565						14
15									15
16	A/C Units	2008	19,600						16
17	4 Ton A/C Unit	2008	2,600						17
18	HVAC Rooftop Unit	2008	11,000						18
19									19
20	Patio	2009	11,693						20
21	Front Entry Doors	2009	13,529						21
22	Front Office Carpet and Window Treatments	2009	3,864						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,555,869	\$ 98,280		\$ 107,194	\$ 8,914	\$ 1,317,080	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	\$ 694,494	\$ 33,351	\$ 33,351	\$		\$ 620,366	71
72	Current Year Purchases	25,553						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 720,047	\$ 33,351	\$ 33,351	\$		\$ 620,366	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)	\$ 3,355,916	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 131,631	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 140,545	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,914	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,937,446	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

9. Option to Buy: YES NO Terms: _____ *

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

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

16. Rental Amount for movable equipment: \$ 1,976 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		2,815		2,815
3	Classroom Wages (a)				
4	Clinical Wages (b)		1,936		1,936
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 4,751	\$	\$ 4,751
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,751		

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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 352,558	\$		\$ 352,558	1
2	Licensed Speech and Language Development Therapist		hrs				91,885			91,885	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				295,632	3,264		298,896	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					190,169		190,169	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						6,891			6,891	13
14	TOTAL			\$			\$ 746,966	\$ 193,433		\$ 940,399	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-Elgin# 0048132Report Period Beginning: 01/01/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 800	\$	1
2	Cash-Patient Deposits	49,147		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	724,077		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,300		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(252,390)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 543,934	\$	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)	\$ 543,934	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 205,026	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,147		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	262,551		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,690		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)	\$ 519,414	\$	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)	\$ 519,414	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 24,520	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 543,934	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 45,005	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 45,005	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(20,485)	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)	\$ (20,485)	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)	\$ 24,520	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Elgin# 0048132Report 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	\$ 5,547,539	1
2	Discounts and Allowances for all Levels	(2,684,822)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,862,717	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,389,806	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,389,806	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	(85)	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	334,755	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	45	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 334,715	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,078	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,078	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)	\$ 5,593,316	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	968,503	31
32	Health Care	2,982,907	32
33	General Administration	1,237,665	33
B. Capital Expense			
34	Ownership	424,726	34
C. Ancillary Expense			
35	Special Cost Centers		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)*	\$ 5,613,801	40
41	Income before Income Taxes (line 30 minus line 40)**	(20,485)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (20,485)	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-Elgin

0048132

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	1,960	2,080	\$ 82,162	\$ 39.50	1
2	Assistant Director of Nursing	1,920	2,080	73,084	35.14	2
3	Registered Nurses	13,449	15,118	478,285	31.64	3
4	Licensed Practical Nurses	8,297	8,697	215,527	24.78	4
5	CNAs & Orderlies	51,087	55,134	865,481	15.70	5
6	CNA Trainees	150	150	1,936	12.91	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,200	3,384	60,544	17.89	8
9	Activity Director					9
10	Activity Assistants	5,621	5,942	74,478	12.53	10
11	Social Service Workers	1,888	2,080	33,027	15.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,214	21,035	258,312	12.28	15
16	Dishwashers					16
17	Maintenance Workers	4,182	4,678	79,135	16.92	17
18	Housekeepers	8,806	9,338	100,878	10.80	18
19	Laundry	2,513	3,977	47,723	12.00	19
20	Administrator	1,900	2,080	103,312	49.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,201	10,299	213,529	20.73	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)	133,388	146,072	\$ 2,687,413 *	\$ 18.40	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	6,000		36
37	Medical Records Consultant	1,055		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,820		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	3,620		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 13,495		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0	50
51	Licensed Practical Nurses	0	0	51
52	Certified Nurse Assistants/Aides	0	0	52
53	TOTAL (lines 50 - 52)		\$	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Linda Hartman			\$ 103,312	Workers' Compensation Insurance	\$ 9,614	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	0	
				FICA Taxes	221,244	Health Care Worker Background Check (Indicate # of checks performed)	960	
				Employee Health Insurance	162,390	Central Office	7,482	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*	0		22,554	
				Other Benefits	12,554	Dues & Subscriptions	6,140	
				Central Office Allocation	30,317	License & Fees	1,159	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 103,312	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (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
Heritage Operations Group	Mgt Fee		\$ 214,177				Out-of-State Travel	\$
			0					
							In-State Travel	
								4,624
								0
							Seminar Expense	4,592
								0
							Central Office	8,527
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 241,441	TOTAL		\$	TOTAL	\$ 17,743

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heritage Manor-Elgin# 0048132Report 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 Elgin 38307 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 51,465
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.