

Facility Name & ID Number Heritage Manor-Gibson City

0048116 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	75	Skilled (SNF)	75	27,375	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	75	TOTALS	75	27,375	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	4 Private Pay	Other	Total		
8	SNF	14,182	5,870	828	20,880	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	14,182	5,870	828	20,880	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.27%

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 828

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-Gibson City # 0048116 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	176,659	7,386		184,045		184,045	2,924	186,969		1
2	Food Purchase		104,154		104,154		104,154	1	104,155		2
3	Housekeeping	52,719	13,500		66,219		66,219		66,219		3
4	Laundry	32,156	6,261		38,417		38,417		38,417		4
5	Heat and Other Utilities			55,336	55,336		55,336	1,498	56,834		5
6	Maintenance	65,495	29,880	45,479	140,854		140,854	14,932	155,786		6
7	Other (specify):*										7
8	TOTAL General Services	327,029	161,181	100,815	589,025		589,025	19,355	608,380		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200	1,454	8,654		9
10	Nursing and Medical Records	957,845	75,539	85,745	1,119,129		1,119,129		1,119,129		10
10a	Therapy		137,201	94,680	231,881	(142,191)	89,690	105,102	194,792		10a
11	Activities	50,453	4,276		54,729		54,729	651	55,380		11
12	Social Services	30,675		3,087	33,762		33,762		33,762		12
13	CNA Training							1,064	1,064		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,038,973	217,016	190,712	1,446,701	(142,191)	1,304,510	108,271	1,412,781		16
	C. General Administration										
17	Administrative	59,263			59,263		59,263		59,263		17
18	Directors Fees										18
19	Professional Services			149,097	149,097		149,097	(139,925)	9,172		19
20	Dues, Fees, Subscriptions & Promotions			62,953	62,953	(41,063)	21,890	(1,084)	20,806		20
21	Clerical & General Office Expenses	116,949	10,441	6,459	133,849		133,849	184,223	318,072		21
22	Employee Benefits & Payroll Taxes			315,810	315,810		315,810	24,189	339,999		22
23	Inservice Training & Education			2,390	2,390		2,390	757	3,147		23
24	Travel and Seminar			6,018	6,018		6,018	6,803	12,821		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			46,834	46,834		46,834	8,083	54,917		26
27	Other (specify):*			850	850		850	(850)			27
28	TOTAL General Administration	176,212	10,441	590,411	777,064	(41,063)	736,001	82,196	818,197		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,542,214	388,638	881,938	2,812,790	(183,254)	2,629,536	209,822	2,839,358		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.

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							101,150	101,150			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,807	8,807		8,807	53,488	62,295			32
33	Real Estate Taxes							40,006	40,006			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(323,846)	4,654			34
35	Rent-Equipment & Vehicles			21,741	21,741		21,741	1,236	22,977			35
36	Other (specify):*											36
37	TOTAL Ownership			359,048	359,048		359,048	(127,966)	231,082			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					142,191	142,191		142,191			39
40	Barber and Beauty Shops			3,694	3,694		3,694		3,694			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					41,063	41,063		41,063			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			3,694	3,694	183,254	186,948		186,948			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,542,214	388,638	1,244,680	3,175,532		3,175,532	81,856	3,257,388			45

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

Heritage Manor-Gibson City

ID# 0048116

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		(628)	20	17
18				18
19			24	19
20		(850)	27	20
21				21
22		(9,919)	19	22
23				23
24		0	27	24
25		(6,426)	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	(17,823)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Gibson City# 0048116

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	2,924	0	0	0	0	0	0	0	0	2,924	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	1,498	0	0	0	0	0	0	0	0	1,498	5
6	Maintenance	0	0	14,932	0	0	0	0	0	0	0	0	14,932	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	19,355	0	0	0	0	0	0	0	0	19,355	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,454	0	0	0	0	0	0	0	0	1,454	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	105,102	0	0	0	0	0	0	0	0	0	105,102	10a
11	Activities	0	0	651	0	0	0	0	0	0	0	0	651	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,064	0	0	0	0	0	0	0	0	1,064	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	105,102	3,169	0	0	0	0	0	0	0	0	108,271	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	(9,919)	(139,178)	9,172	0	0	0	0	0	0	0	0	(139,925)	19
20	Fees, Subscriptions & Promotions	(7,054)	0	5,970	0	0	0	0	0	0	0	0	(1,084)	20
21	Clerical & General Office Expenses	0	0	184,223	0	0	0	0	0	0	0	0	184,223	21
22	Employee Benefits & Payroll Taxes	0	0	24,189	0	0	0	0	0	0	0	0	24,189	22
23	Inservice Training & Education	0	0	757	0	0	0	0	0	0	0	0	757	23
24	Travel and Seminar	0	0	6,803	0	0	0	0	0	0	0	0	6,803	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	8,083	0	0	0	0	0	0	0	0	8,083	26
27	Other (specify):*	(850)	0	0	0	0	0	0	0	0	0	0	(850)	27
28	TOTAL General Administration	(17,823)	(139,178)	239,197	0	0	0	0	0	0	0	0	82,196	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,823)	(34,076)	261,721	0	0	0	0	0	0	0	0	209,822	29

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Gibson City# 0048116

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	94,037	0	7,113	0	0	0	0	0	0	0	101,150	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,222)	55,461	0	249	0	0	0	0	0	0	0	53,488	32
33	Real Estate Taxes	0	40,006	0	0	0	0	0	0	0	0	0	40,006	33
34	Rent-Facility & Grounds	0	(328,500)	0	4,654	0	0	0	0	0	0	0	(323,846)	34
35	Rent-Equipment & Vehicles	0	0	0	1,236	0	0	0	0	0	0	0	1,236	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,222)	(138,996)	0	13,252	0	(127,966)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(20,045)	(173,072)	261,721	13,252	0	0	0	0	0	0	0	81,856	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>105,102</u>	<u>105,102</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>139,178</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(139,178)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>328,500</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(328,500)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>40,006</u>	<u>40,006</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>49,004</u>	<u>49,004</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>94,037</u>	<u>94,037</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>6,457</u>	<u>6,457</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>467,678</u>			\$ <u>294,606</u>	\$ * <u>(173,072)</u>	14

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

Facility Name & ID Number Heritage Manor-Gibson City# 0048116Report Period Beginning: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$	\$ 2,924	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					1,498	19
20	V	6 Maintenance					14,932	20
21	V	7 Other					0	21
22	V	9 Medical Director					1,454	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					651	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,064	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					0	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					9,172	31
32	V	20 Fees, Subscription, Promotions					5,970	32
33	V	21 Clerical & General Office Expenses					184,223	33
34	V	22 Employee Benefits & Payroll Taxes					24,189	34
35	V	23 Inservice Training & Education					757	35
36	V	24 Travel and Seminar					6,803	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					8,083	38
39	Total		\$			\$	0	\$ * 261,721 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	27 Other	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	0	15	
16	V	30 Depreciation						7,113	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						249	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						4,654	20	
21	V	35 Rent-Equipment & Vehicles						1,236	21	
22	V	36 Other						0	22	
23	V	38 Medically Nec Transportation						0	23	
24	V	39 Ancillary Service Centers						0	24	
25	V	40 Barber and Beauty Shops						0	25	
26	V	41 Coffee and Gift Shops						0	26	
27	V	42 Other						0	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total		\$			\$	0	\$ *	13,252	39

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

Facility Name & ID Number

Heritage Manor-Gibson City

0048116

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-Gibson City# 0048116

Report Period Beginning:

01/01/2009Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Heritage Operations Group

Street Address

box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 102,708	\$ 102,349	75	\$ 2,924	1
2	2	Food Purchase	Beds	2,634	25	29	0	75	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	75	0	3
4	4	Laundry	Beds	2,634	25	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	75	1,498	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	75	14,932	6
7	7	Other	Beds	2,634	25	0	0	75	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	75	1,454	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	75	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	75	651	10
11	12	Social Service	Beds	2,634	25	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	75	1,064	12
13	14	Program Transportation	Beds	2,634	25	0	0	75	0	13
14	15	Other	Beds	2,634	25	0	0	75	0	14
15	17	Administrative	Beds	2,634	25	0	0	75	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	75	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	75	9,172	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	75	5,970	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	75	184,223	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	75	24,189	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	75	757	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	75	6,803	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	75	8,083	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 261,721	25

Facility Name & ID Number Heritage Manor-Gibson City

0048116

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	25	\$	75	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	75	7,113	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		75		3
4	32	Interest	Beds	2,634	25	8,747	75	249	4
5	33	Real Estate Taxes	Beds	2,634	25		75		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	75	4,654	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	75	1,236	7
8	36	Other	Beds	2,634	25		75		8
9	38	Medically Nec Transportation	Beds	2,634	25		75		9
10	39	Ancillary Service Centers	Beds	2,634	25		75		10
11	40	Barber and Beauty Shops	Beds	2,634	25		75		11
12	41	Coffee and Gift Shops	Beds	2,634	25		75		12
13	42	Other	Beds	2,634	25		75		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 465,371	\$	\$ 13,252	25

Facility Name & ID Number

Heritage Manor-Gibson City

0048116

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												
												Name of Lender	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			\$	\$ 726,243	03/11	variable	\$ 49,004	1										
2	Bank of America		xx	Loan Fees							6,457	2										
3												3										
4												4										
5												5										
	Working Capital																					
6	Bank of America		xx	Accounts Receivable							8,807	6										
7												7										
8												8										
9	TOTAL Facility Related						\$	\$ 726,243			\$ 64,268	9										
	B. Non-Facility Related*																					
10	Interest Income										(2,222)	10										
11	Allocated Corporate										249	11										
12												12										
13												13										
14	TOTAL Non-Facility Related						\$	\$			\$ (1,973)	14										
15	TOTALS (line 9+line14)						\$	\$ 726,243			\$ 62,295	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.)		\$	40,006	2
3. Under or (over) accrual (line 2 minus line 1).		\$	40,006	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.		\$	40,006	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	36,943		8
	2005	42,119		9
	2006	39,581		10
	2007	39,352		11
	2008	40,006		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.

IMPORTANT NOTICE

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

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

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

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

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Gibson City COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0048116

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>091111482001</u>	<u>nursing home</u>	\$ <u>39,862.00</u>	\$ <u>39,862.00</u>
2.	<u>091111479017</u>	_____	\$ <u>144.00</u>	\$ <u>144.00</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>40,006.00</u>	\$ <u>40,006.00</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-Gibson City

0048116

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,183 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>20,000</u>	1
2					2
3	TOTALS			\$ <u>20,000</u>	3

Facility Name & ID Number Heritage Manor-Gibson City

0048116

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	75				\$ 815,350	\$		\$	\$	\$
5					912,769					
6										
7										
8										
	Improvement Type**									
9	1981 Improvements		1981		41,753					
10	1982 Improvements		1982		6,437					
11	1983 Improvements		1983		240					
12	1984 Improvements		1984		873					
13	1985 Improvements		1985		7,530					
14	1986 Improvements		1986		20,979					
15	1987 Improvements		1987		2,222					
16	1988 Improvements		1988		2,452					
17	1989 Improvements		1989		28,639					
18	1990 Improvements		1990		99,326					
19	1991 Improvements		1991		36,637					
20	1993 Improvements		1993		40,838					
21	1994 Improvements		1994		66,399					
22	1995 Improvements		1995		1,060					
23	WINDOW REPLACEMENTS		1996		25,247					
24	WATER HEATER		1996		1,639					
25	RESIDENT ROOM REMODEL/PAINTING		1996		7,584					
26	Parking Lot		1998		12,299					
27										
28	Smoke Dampers		1999		5,256					
29	Water Heater		1999		1,971					
30	Garbage Disposal		1999		1,693					
31	Heat/Cool compressor		1999		3,277					
32	Smoke Dampers		2000		1,295					
33										
34	C/O Allocation							7,113	7,113	
35	Book Depreciation					68,784		68,784		1,098,455
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-Gibson City# 0048116

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	Temperature Control Unit	2001	\$ 1,700	\$		\$	\$	\$	37
38	AC Replacement	2001	4,400						38
39	Smoke Detection System								39
40									40
41	Smoke Detection System	2002	1,775						41
42	Landscaping	2002	1,425						42
43	Fire Supression	2002	4,458						43
44	Water Heater	2002	2,396						44
45	Keypad Perimeter	2002	941						45
46	Sealcoat Parking Lot	2002	1,371						46
47	Garbage Disposal	2002	1,520						47
48	Hot Water Tank	2002	3,168						48
49	Rehab Hallway--Wallpaper/Paint	2002	14,442						49
50									50
51	Exterior Doors	2003	2,195						51
52	Roof Replacement	2003	28,555						52
53	Security Door	2003	1,116						53
54	Water Heater	2003	1,999						54
55	Water Tank	2003	1,836						55
56									56
57	HVAC unit	2004	5,247						57
58	Grease Trap	2004	1,903						58
59	Quarry Tile	2004	3,165						59
60	Parking Lot Sealcoat	2004	1,579						60
61	HVAC unit	2004	1,000						61
62	Sprinkler Leak	2004	1,854						62
63	Hot Water Boiler	2004	2,133						63
64	Corridor Remodel Material and Labor	2004	20,242						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,254,185	\$ 68,784		\$ 75,897	\$ 7,113	\$ 1,098,455	70

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

Facility Name & ID Number Heritage Manor-Gibson City

0048116

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,254,185	\$ 68,784		\$ 75,897	\$ 7,113	\$ 1,098,455	1
2	Oxygen Room	2005	2,005						2
3	Heat/Cool Unit	2005	17,228						3
4									4
5	Heat/Cool Units	2006	25,182						5
6	Door	2006	2,887						6
7	Heater	2006	1,078						7
8	Sidewalk	2006	3,500						8
9	Boiler	2006	1,427						9
10	Remodel TLC Unit --carpet, paint,	2006	27,516						10
11	Parking Lot sealer	2006	1,699						11
12	Drapes	2006	1,172						12
13	adjustments	2006	(7,711)						13
14	dishwasher motor	2007							14
15	Remodel TLC Unit --carpet, paint,	2007	2,996						15
16	Water Heater	2007	2,907						16
17	Grease Trap	2007							17
18	Water Softener	2007	12,285						18
19									19
20	Emergency Alarms	2008	36,893						20
21									21
22	Water Heater	2008	4,982						22
23	Exterior Painting	2008	9,720						23
24									24
25	Sprinkler System	2009	11,980						25
26	Water Heater	2009	4,503						26
27	Generator	2009	26,450						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,442,884	\$ 68,784		\$ 75,897	\$ 7,113	\$ 1,098,455	34

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

Facility Name & ID Number Heritage Manor-Gibson City

0048116

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 455,079	\$ 25,253	\$ 25,253	\$		\$ 434,694	71
72	Current Year Purchases	900						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 455,979	\$ 25,253	\$ 25,253	\$		\$ 434,694	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,918,863	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,037	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,150	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,113	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,533,149	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: \$ 21,741 Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 47,328	\$		\$ 47,328	1
2	Licensed Speech and Language Development Therapist		hrs			224			224	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			42,138	0		42,138	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				137,201		137,201	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					4,990			4,990	13
14	TOTAL			\$		\$ 94,680	\$ 137,201		\$ 231,881	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-Gibson City

0048116

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 17,283	\$	1
2	Cash-Patient Deposits	10,055		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	239,147		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,521		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,148,117)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (866,111)	\$	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)	\$ (866,111)	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 74,042	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,055		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	110,885		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,606		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)	\$ 213,588	\$	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)	\$ 213,588	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,079,699)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (866,111)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (801,182)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (801,182)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(278,517)	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)	\$ (278,517)	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)	\$ (1,079,699)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Gibson City# 0048116Report 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	\$ 2,936,887	1
2	Discounts and Allowances for all Levels	(552,185)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,384,702	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	312,019	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 312,019	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,129	12
13	Barber and Beauty Care	5,912	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	216,031	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 225,072	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,222	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,222	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)	\$ 2,924,015	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	589,025	31
32	Health Care	1,446,701	32
33	General Administration	777,064	33
B. Capital Expense			
34	Ownership	359,048	34
C. Ancillary Expense			
35	Special Cost Centers	3,694	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	<u>Other</u>	27,000	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,202,532	40
41	Income before Income Taxes (line 30 minus line 40)**	(278,517)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (278,517)	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-Gibson City**

0048116

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	2,000	2,160	\$ 57,617	\$ 26.67	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,212	4,543	124,080	27.31	3
4	Licensed Practical Nurses	10,146	10,535	255,553	24.26	4
5	CNAs & Orderlies	36,645	38,820	458,876	11.82	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,053	3,839	61,719	16.08	8
9	Activity Director					9
10	Activity Assistants	4,042	4,212	50,453	11.98	10
11	Social Service Workers	1,937	2,191	30,675	14.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,736	17,830	176,659	9.91	15
16	Dishwashers					16
17	Maintenance Workers	5,061	5,452	65,495	12.01	17
18	Housekeepers	6,231	6,777	52,719	7.78	18
19	Laundry	1,828	2,018	32,156	15.93	19
20	Administrator	1,900	2,080	59,263	28.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,218	7,383	116,949	15.84	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)	99,009	107,840	\$ 1,542,214 *	\$ 14.30	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	7,200		36
37	Medical Records Consultant	1,840		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,250		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	3,087		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 14,377		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,035	\$ 41,393	50
51	Licensed Practical Nurses	1,129	39,509	51
52	Certified Nurse Assistants/Aides	0	0	52
53	TOTAL (lines 50 - 52)	2,164	\$ 80,902	53

Facility Name & ID Number Heritage Manor-Gibson City# 0048116Report 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 Gibson City 38315 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,773
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.