		FOR BHF USE					

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

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

I. IDPH License ID Number: 0048108

Facility Name: Heritage Manor-Mendota

Address: 1201 First Avenue (Number) Mendota (City) 61342 (Zip Code)

County: LaSalle

Telephone Number: (815) 539-6745 **Fax #** ( )

HFS ID Number: 203904038001

Date of Initial License for Current Owners: 07/2006

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		xx	Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2009 to 12/31/2009 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	Craig L. Ater
	(Title)	Exec V.P. & CFO
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Craig L. Ater Exec V.P. & CFO
	(Firm Name & Address)	Heritage Operations Group, LLC.
	(Telephone)	( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Craig Ater Telephone Number: (309)823-7135
Email Address: cater@heritageofcare.com

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,232	9,951	2,575	25,758	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,232	9,951	2,575	25,758	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.28%

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 [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

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 [x] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified _____ and days of care provided 2,575

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	212,599	23,861		236,460		236,460	3,860	240,320			1
2	Food Purchase		151,499		151,499		151,499	1	151,500			2
3	Housekeeping	75,785	17,256		93,041		93,041		93,041			3
4	Laundry	60,818	17,291		78,109		78,109		78,109			4
5	Heat and Other Utilities			90,355	90,355		90,355	1,977	92,332			5
6	Maintenance	57,247	38,512	48,933	144,692		144,692	19,711	164,403			6
7	Other (specify):*											7
8	**TOTAL General Services**	406,449	248,419	139,288	794,156		794,156	25,549	819,705			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400	1,919	10,319			9
10	Nursing and Medical Records	1,571,592	102,283	46,708	1,720,583		1,720,583		1,720,583			10
10a	Therapy		217,316	361,957	579,273	(243,317)	335,956	100,020	435,976			10a
11	Activities	75,496	5,198		80,694		80,694	859	81,553			11
12	Social Services	32,384		1,115	33,499		33,499		33,499			12
13	CNA Training	969	731		1,700		1,700	1,404	3,104			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,680,441	325,528	418,180	2,424,149	(243,317)	2,180,832	104,202	2,285,034			16
	C. General Administration											
17	Administrative	86,175			86,175		86,175		86,175			17
18	Directors Fees											18
19	Professional Services			214,581	214,581		214,581	(202,474)	12,107			19
20	Dues, Fees, Subscriptions & Promotions			84,525	84,525	(54,203)	30,322	(11,364)	18,958			20
21	Clerical & General Office Expenses	147,093	27,373	8,855	183,321		183,321	243,174	426,495			21
22	Employee Benefits & Payroll Taxes			495,609	495,609		495,609	31,930	527,539			22
23	Inservice Training & Education			3,668	3,668		3,668	1,000	4,668			23
24	Travel and Seminar			5,367	5,367		5,367	8,980	14,347			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,192	43,192		43,192	10,669	53,861			26
27	Other (specify):*			54,250	54,250		54,250	(54,250)				27
28	**TOTAL General Administration**	233,268	27,373	910,047	1,170,688	(54,203)	1,116,485	27,665	1,144,150			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,320,158	601,320	1,467,515	4,388,993	(297,520)	4,091,473	157,416	4,248,889			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-Mendota #0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							152,573	152,573			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,633	11,633		11,633	112,968	124,601			32
33	Real Estate Taxes							44,076	44,076			33
34	Rent-Facility & Grounds			433,620	433,620		433,620	(428,123)	5,497			34
35	Rent-Equipment & Vehicles			91	91		91	1,631	1,722			35
36	Other (specify):*											36
37	TOTAL Ownership			445,344	445,344		445,344	(116,875)	328,469			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					243,317	243,317		243,317			39
40	Barber and Beauty Shops			7,781	7,781		7,781		7,781			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					54,203	54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			7,781	7,781	297,520	305,301		305,301			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,320,158	601,320	1,920,640	4,842,118		4,842,118	40,541	4,882,659			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-Mendota # 0048108 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(646)	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	(5,016)	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	(960)	20		17
18	Fines and Penalties				18
19	Entertainment		24		19
20	Contributions	(250)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,769)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(54,000)	27		24
25	Fund Raising, Advertising and Promotional	(18,284)	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)**	$ (84,925)		$	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 Amount	2 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)	125,466		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 125,466		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 40,541		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

Heritage Manor-Mendota

ID# 0048108

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		(960)	20	17
18				18
19			24	19
20		(250)	27	20
21				21
22		(5,769)	19	22
23				23
24		(54,000)	27	24
25		(18,284)	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	(79,263)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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	3,860	0	0	0	0	0	0	0	0	3,860	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	1,977	0	0	0	0	0	0	0	0	1,977	5
6	Maintenance	0	0	19,711	0	0	0	0	0	0	0	0	19,711	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	25,549	0	0	0	0	0	0	0	0	25,549	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,919	0	0	0	0	0	0	0	0	1,919	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	100,020	0	0	0	0	0	0	0	0	0	100,020	10a
11	Activities	0	0	859	0	0	0	0	0	0	0	0	859	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,404	0	0	0	0	0	0	0	0	1,404	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	100,020	4,182	0	0	0	0	0	0	0	0	104,202	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	(5,769)	(208,812)	12,107	0	0	0	0	0	0	0	0	(202,474)	19
20	Fees, Subscriptions & Promotions	(19,244)	0	7,880	0	0	0	0	0	0	0	0	(11,364)	20
21	Clerical & General Office Expenses	0	0	243,174	0	0	0	0	0	0	0	0	243,174	21
22	Employee Benefits & Payroll Taxes	0	0	31,930	0	0	0	0	0	0	0	0	31,930	22
23	Inservice Training & Education	0	0	1,000	0	0	0	0	0	0	0	0	1,000	23
24	Travel and Seminar	0	0	8,980	0	0	0	0	0	0	0	0	8,980	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	10,669	0	0	0	0	0	0	0	0	10,669	26
27	Other (specify):*	(54,250)	0	0	0	0	0	0	0	0	0	0	(54,250)	27
28	**TOTAL General Administration**	(79,263)	(208,812)	315,740	0	0	0	0	0	0	0	0	27,665	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(79,263)	(108,792)	345,471	0	0	0	0	0	0	0	0	157,416	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Mendota # 0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	143,184	0	9,389	0	0	0	0	0	0	0	152,573	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,016)	117,655	0	329	0	0	0	0	0	0	0	112,968	32
33	Real Estate Taxes	0	44,076	0	0	0	0	0	0	0	0	0	44,076	33
34	Rent-Facility & Grounds	(646)	(433,620)	0	6,143	0	0	0	0	0	0	0	(428,123)	34
35	Rent-Equipment & Vehicles	0	0	0	1,631	0	0	0	0	0	0	0	1,631	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,662)	(128,705)	0	17,492	0	0	0	0	0	0	0	(116,875)	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)	(84,925)	(237,497)	345,471	17,492	0	0	0	0	0	0	0	40,541	45

Facility Name & ID Number Heritage Manor-Mendota # 0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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
Heritage Enterprises, Inc.	100%	See Attached				

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. [x] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	100,020	100,020	2
3	V								3
4	V	19	Adjustment for Related Organization	208,812	Heritage Operations Group, LLC	0.00%		(208,812)	4
5	V								5
6	V	34	Adjustment for Related Organization	433,620	Heritage Manor Real Estate, LLC	0.00%		(433,620)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		44,076	44,076	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		110,940	110,940	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		143,184	143,184	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		6,715	6,715	10
11	V								11
12	V								12
13	V								13
14	Total			$ 642,432			$ 404,935	$ * (237,497)	14

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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%	$	$ 3,860	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					1,977	19
20	V	6	Maintenance					19,711	20
21	V	7	Other					0	21
22	V	9	Medical Director					1,919	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					859	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					1,404	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					12,107	31
32	V	20	Fees, Subscription, Promotions					7,880	32
33	V	21	Clerical & General Office Expenses					243,174	33
34	V	22	Employee Benefits & Payroll Taxes					31,930	34
35	V	23	Inservice Training & Education					1,000	35
36	V	24	Travel and Seminar					8,980	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					10,669	38
39	Total			$			$ 0	$ * 345,471	39

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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	27	Other	$	Heritage Enterprises, Inc.	0.00%	$	$ 0	15
16	V	30	Depreciation					9,389	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					329	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,143	20
21	V	35	Rent-Equipment & Vehicles					1,631	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	$ * 17,492	39

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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-Mendota # 0048108 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,634	25	$ 102,708	$ 102,349	99	$ 3,860	1
2	2	Food Purchase	Beds	2,634	25	29	0	99	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	99	0	3
4	4	Laundry	Beds	2,634	25	0	0	99	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	99	1,977	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	99	19,711	6
7	7	Other	Beds	2,634	25	0	0	99	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	99	1,919	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	99	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	99	859	10
11	12	Social Service	Beds	2,634	25	0	0	99	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	99	1,404	12
13	14	Program Transportation	Beds	2,634	25	0	0	99	0	13
14	15	Other	Beds	2,634	25	0	0	99	0	14
15	17	Administrative	Beds	2,634	25	0	0	99	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	99	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	99	12,107	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	99	7,880	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	99	243,174	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,634	25	849,520	0	99	31,930	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	99	1,000	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	99	8,980	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	99	10,669	24
25	TOTALS					$ 9,191,616	$ 6,527,897		$ 345,471	25

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	25	$	$	99	$	1
2	30	Depreciation	Beds	2,634	25	249,793		99	9,389	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25			99		3
4	32	Interest	Beds	2,634	25	8,747		99	329	4
5	33	Real Estate Taxes	Beds	2,634	25			99		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432		99	6,143	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399		99	1,631	7
8	36	Other	Beds	2,634	25			99		8
9	38	Medically Nec Transportation	Beds	2,634	25			99		9
10	39	Ancillary Service Centers	Beds	2,634	25			99		10
11	40	Barber and Beauty Shops	Beds	2,634	25			99		11
12	41	Coffee and Gift Shops	Beds	2,634	25			99		12
13	42	Other	Beds	2,634	25			99		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	$		$ 17,492	25

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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			$	$ 1,615,841	03/11	variable	$ 108,911	1
2	Bank of America		xx	Loan Fees							6,715	2
3	Alpha Bank		xx	Van				22,130			2,029	3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							11,633	6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,637,971			$ 129,288	9
	B. Non-Facility Related*											
10	Interest Income										(5,016)	10
11	Allocated Corporate										329	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,687)	14
15	TOTALS (line 9+line14)						$	$ 1,637,971			$ 124,601	15

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

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

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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.)	$ 44,076	2
3. Under or (over) accrual (line 2 minus line 1).	$ 44,076	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.	$ 44,076	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2004	26,183	8
2005	32,066	9
2006	73,732	10
2007	42,424	11
2008	44,076	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-Mendota COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048108

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	0134100020	nursing home	$ 44,076.00	$ 44,076.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 44,076.00	$ 44,076.00

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-Mendota # 0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,555 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [XX] (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 [XX] (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 [X] 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				$ 26,150	1
2					2
3	TOTALS			$ 26,150	3

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99				$ 697,500	$		$	$	$	4
5					408,657						5
6											6
7											7
8											8
	Improvement Type**										
9	1980 Improvements			1980	8,150						9
10	1981 Improvements			1981	20,492						10
11	1982 Improvements			1982	9,185						11
12	1983 Improvements			1983	5,682						12
13	1984 Improvements			1984	11,488						13
14	1985 Improvements			1985	7,710						14
15	1986 Improvements			1986	2,255						15
16	1987 Improvements			1987	9,037						16
17	1988 Improvements			1988	21,297						17
18	1989 Improvements			1989	4,653						18
19	1990 Improvements			1990	36,595						19
20	1991 Improvements			1991							20
21	1992 Improvements			1992	10,646						21
22	1993 Improvements			1993	62,261						22
23	1994 Improvements			1994	10,869						23
24	1995 Improvements			1995	18,523						24
25	Exterior Door			1996	2,563						25
26	Shower Tile			1996	806						26
27	Kitchen Heat/Cool Unit			1996	14,062						27
28	Resident Room Painting			1996	2,067						28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							9,389	9,389		34
35	Book Depreciation					103,316		103,316		1,184,118	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Garbage Disposal	1997	$ 2,030	$		$	$	$	37
38	Generator	1997	39,380						38
39	Parking Lot Asphalt	1997	2,210						39
40	Shower	1997	701						40
41									41
42	Kitchen Drain	1998	3,245						42
43	Walk in Cooler Repair	1998	2,215						43
44	A/C Unit	1998	1,615						44
45	Landscaping	1998	4,696						45
46									46
47	Door Alarm System	1999	11,750						47
48	Air Conditioning Condensing Unit	1999	1,027						48
49	Water Softener	1999	4,493						49
50									50
51	Air conditioner (3)	2000	2,221						51
52	Sprinklers	2000	1,864						52
53	Resident Room Doors (45)	2000	1,724						53
54	Facility Remodel -- Materials (see attached detail)	2000	410,365						54
55	Facility Remodel -- Labor (see attached detail)	2000	4,030						55
56	Facility Remodel -- Professional Fees (see attached detail)	2000	23,932						56
57	Facility Remodel -- Interior Design (see attached detail)	2000	36,998						57
58	Water Softener	2000	4,713						58
59									59
60	Parking Spaces	2001	1,452						60
61	Water Heater	2001	2,847						61
62									62
63	Water Heater	2002	3,816						63
64	Wood door	2002	677						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,932,499	$ 103,316		$ 112,705	$ 9,389	$ 1,184,118	70

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,932,499	$ 103,316		$ 112,705	$ 9,389	$ 1,184,118	1
2	Furnace	2003	2,491						2
3	A/C Unit	2003	3,083						3
4	Condensing Unit	2003	1,353						4
5									5
6	Heat/Cool Unit	2004	2,498						6
7	Disposal	2004	989						7
8	Garage Repairs	2004	4,866						8
9	Compressor	2004	1,805						9
10	Emergency Outlets	2004	1,565						10
11	Furnace	2004	6,280						11
12									12
13	Exterior Door	2005	3,161						13
14	Holding Tank	2005	3,897						14
15	Smoke Detector	2005	1,919						15
16	A/C Unit	2005	4,248						16
17	Parking Lot	2005	68,313						17
18	Dumpster Pad	2005	1,547						18
19	Sidewalks	2005	7,850						19
20									20
21	Floor -- entry way	2006	19,178						21
22	Shower rehab	2006	6,246						22
23	Phone system	2006	1,836						23
24	A/C Unit	2006	2,201						24
25	Compressor	2006	1,642						25
26	Remodel TLC unit -- paint, wallpaper	2006	6,126						26
27	Parking Lot	2006	3,633						27
28	Roof	2006	148,938						28
29	Valance	2006	581						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,238,745	$ 103,316		$ 112,705	$ 9,389	$ 1,184,118	34

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,238,745	$ 103,316		$ 112,705	$ 9,389	$ 1,184,118	1
2	Metal Roof	2007	49,988						2
3	Door Alarm	2007	2,986						3
4	HVAC	2007	3,370						4
5	Sprinkler system	2007	101,380						5
6	Wander Alarm	2007	8,092						6
7	fire Alarm	2007	42,223						7
8	Water Heater	2007	3,820						8
9	Grab Bars	2007	4,193						9
10									10
11	Heat/Cool Units	2008	2,713						11
12									12
13	Water Heater	2009	6,340						13
14	Sidewalks	2009	35,988						14
15	Furnace	2009	4,190						15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,504,028	$ 103,316		$ 112,705	$ 9,389	$ 1,184,118	34

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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	$ 854,614	$ 39,868	$ 39,868	$		$ 708,325	71
72	Current Year Purchases	25,470						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 880,084	$ 39,868	$ 39,868	$		$ 708,325	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)	$ 3,410,262	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,184	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,573	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,389	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,892,443	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.

Facility Name & ID Number Heritage Manor-Mendota # 0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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: *

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	$

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: $ 91 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.

Facility Name & ID Number Heritage Manor-Mendota # 0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		731		731
3	Classroom Wages (a)				
4	Clinical Wages (b)		969		969
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 1,700	$	$ 1,700
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,700			

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.

Facility Name & ID Number Heritage Manor-Mendota # 0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

		1	2	3	4	5	6	7	8	
	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	$		$ 150,100	$		$ 150,100	1
2	Licensed Speech and Language Development Therapist		hrs			7,407			7,407	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			177,196	1,253		178,449	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				216,063		216,063	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					27,254			27,254	13
14	TOTAL			$		$ 361,957	$ 217,316		$ 579,273	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-Mendota # 0048108 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,612	$	1
2	Cash-Patient Deposits	10,883		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	376,558		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,930		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(408,737)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 26,246	$	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)**	$ 26,246	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 102,645	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,883		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,681		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,757		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)**	$ 328,966	$	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)**	$ 328,966	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (302,720)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 26,246	$	48

*(See instructions.)

Facility Name & ID Number Heritage Manor-Mendota # 0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (87,779)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (87,779)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(214,941)	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)**	$ (214,941)	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)**	$ (302,720)	24 *

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,424,996	1
2	Discounts and Allowances for all Levels	(1,496,615)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,928,381	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,286,471	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,286,471	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	18,121	12
13	Barber and Beauty Care	10,382	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	646	16
17	Sale of Drugs	375,985	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)**	$ 405,134	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,016	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,016	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,625,002	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	794,156	31
32	Health Care	2,424,149	32
33	General Administration	1,170,688	33
	B. Capital Expense		
34	Ownership	445,344	34
	C. Ancillary Expense		
35	Special Cost Centers	7,781	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Other	(2,175)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,839,943	40
41	**Income before Income Taxes (line 30 minus line 40)****	(214,941)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (214,941)	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-Mendota # 0048108 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	1,828	2,080	$ 60,241	$ 28.96	1
2	Assistant Director of Nursing	1,920	2,080	56,518	27.17	2
3	Registered Nurses	11,727	12,402	346,569	27.94	3
4	Licensed Practical Nurses	11,345	11,963	267,735	22.38	4
5	CNAs & Orderlies	60,666	64,510	840,529	13.03	5
6	CNA Trainees	100	100	969	9.69	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	5,921	6,573	75,496	11.49	10
11	Social Service Workers	1,790	2,022	32,384	16.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,482	20,868	212,599	10.19	15
16	Dishwashers					16
17	Maintenance Workers	3,618	4,034	57,247	14.19	17
18	Housekeepers	6,855	7,303	75,785	10.38	18
19	Laundry	6,152	6,692	60,818	9.09	19
20	Administrator	1,900	2,080	86,175	41.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,107	8,062	147,093	18.25	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)	140,411	150,769	$ 2,320,158 *	$ 15.39	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		8,400		36
37	Medical Records Consultant		771		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,970		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,115		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 13,256		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	517	$ 20,697		50
51	Licensed Practical Nurses	621	21,747		51
52	Certified Nurse Assistants/Aides	7	184		52
53	TOTAL (lines 50 - 52)	1,146	$ 42,628		53

Facility Name & ID Number Heritage Manor-Mendota # 0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine McDowell			$ 86,175
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 86,175

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

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt Fee	$ 208,812
		0
		0
		5,769
		0
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 214,581

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,979
Unemployment Compensation Insurance	
FICA Taxes	195,432
Employee Health Insurance	221,678
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	0
Other Benefits	26,520
Central Office Allocation	31,930
TOTAL (agree to Schedule V, line 22, col.8)	$ 527,539

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	1,413
Health Care Worker Background Check (Indicate # of checks performed)	1,020
Central Office	7,880
	9,225
Dues & Subscriptions	6,704
License & Fees	2,901
Less: Public Relations Expense	(9,225)
Non-allowable advertising	(960)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,958

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,057
	0
Seminar Expense	2,310
	0
Central Office	8,980
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,347

**See instructions.

Facility Name & ID Number Heritage Manor-Mendota # 0048108 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	Amount of Expense Amortized Per Year								
					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-Mendota # 0048108 Report 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 Mendota 38364 07/2006

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **54,203**
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 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.