

Facility Name & ID Number Heritage Manor-Minonk

0048058 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	49	Skilled (SNF)	49	17,885	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	23	Sheltered Care (SC)	23	8,395	5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,446	5,722	2,292	15,460	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		4,169		4,169	12
13	DD 16 OR LESS					13
14	TOTALS	7,446	9,891	2,292	19,629	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.69%

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 2,292

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number

Heritage Manor-Minonk

0048058

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	203,635	12,622		216,257		216,257	2,808	219,065		1
2	Food Purchase		113,667		113,667		113,667	1	113,668		2
3	Housekeeping	73,649	12,374		86,023		86,023		86,023		3
4	Laundry	46,320	9,528		55,848		55,848		55,848		4
5	Heat and Other Utilities			88,707	88,707		88,707	1,438	90,145		5
6	Maintenance	56,511	45,082	30,316	131,909		131,909	14,335	146,244		6
7	Other (specify):*										7
8	TOTAL General Services	380,115	193,273	119,023	692,411		692,411	18,582	710,993		8
	B. Health Care and Programs										
9	Medical Director			889	889		889	1,395	2,284		9
10	Nursing and Medical Records	964,640	61,089	4,286	1,030,015		1,030,015		1,030,015		10
10a	Therapy		197,284	238,557	435,841	(207,336)	228,505	98,670	327,175		10a
11	Activities	59,215	3,176		62,391		62,391	625	63,016		11
12	Social Services	36,824		1,937	38,761		38,761		38,761		12
13	CNA Training	3,711	240		3,951		3,951	1,021	4,972		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,064,390	261,789	245,669	1,571,848	(207,336)	1,364,512	101,711	1,466,223		16
	C. General Administration										
17	Administrative	81,846			81,846		81,846		81,846		17
18	Directors Fees										18
19	Professional Services			156,076	156,076		156,076	(147,271)	8,805		19
20	Dues, Fees, Subscriptions & Promotions			44,880	44,880	(26,828)	18,052	(1,311)	16,741		20
21	Clerical & General Office Expenses	103,564	23,357	6,076	132,997		132,997	176,854	309,851		21
22	Employee Benefits & Payroll Taxes			312,710	312,710		312,710	23,222	335,932		22
23	Inservice Training & Education			2,408	2,408		2,408	727	3,135		23
24	Travel and Seminar			13,796	13,796		13,796	6,531	20,327		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			34,830	34,830		34,830	7,759	42,589		26
27	Other (specify):*			25	25		25	(25)			27
28	TOTAL General Administration	185,410	23,357	570,801	779,568	(26,828)	752,740	66,486	819,226		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,629,915	478,419	935,493	3,043,827	(234,164)	2,809,663	186,779	2,996,442		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-Minonk

#0048058

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							101,746	101,746			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,762	5,762		5,762	70,372	76,134			32
33	Real Estate Taxes							37,460	37,460			33
34	Rent-Facility & Grounds			315,360	315,360		315,360	(313,798)	1,562			34
35	Rent-Equipment & Vehicles			1,768	1,768		1,768	1,186	2,954			35
36	Other (specify):*											36
37	TOTAL Ownership			322,890	322,890		322,890	(103,034)	219,856			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					207,336	207,336		207,336			39
40	Barber and Beauty Shops			139	139		139		139			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					26,828	26,828		26,828			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			139	139	234,164	234,303		234,303			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,629,915	478,419	1,258,522	3,366,856		3,366,856	83,745	3,450,601			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-Minonk

0048058

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space	(2,905)	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	(1,367)	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	(545)	20		17
18	Fines and Penalties				18
19	Entertainment		24		19
20	Contributions	(25)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,088)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(6,497)	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)	\$ (16,427)		\$	30

BHF USE ONLY					
48		49		50	51
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	100,172		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 100,172		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 83,745		37

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

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

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

Heritage Manor-Minonk

ID# 0048058

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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		(545)	20	17
18				18
19			24	19
20		(25)	27	20
21				21
22		(5,088)	19	22
23				23
24		0	27	24
25		(6,497)	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		(12,155)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Minonk# 0048058

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	2,808	0	0	0	0	0	0	0	0	2,808	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	1,438	0	0	0	0	0	0	0	0	1,438	5
6	Maintenance	0	0	14,335	0	0	0	0	0	0	0	0	14,335	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	18,582	0	18,582	8							
	B. Health Care and Programs													
9	Medical Director	0	0	1,395	0	0	0	0	0	0	0	0	1,395	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	98,670	0	0	0	0	0	0	0	0	0	98,670	10a
11	Activities	0	0	625	0	0	0	0	0	0	0	0	625	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,021	0	0	0	0	0	0	0	0	1,021	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	98,670	3,041	0	101,711	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	(5,088)	(150,988)	8,805	0	0	0	0	0	0	0	0	(147,271)	19
20	Fees, Subscriptions & Promotions	(7,042)	0	5,731	0	0	0	0	0	0	0	0	(1,311)	20
21	Clerical & General Office Expenses	0	0	176,854	0	0	0	0	0	0	0	0	176,854	21
22	Employee Benefits & Payroll Taxes	0	0	23,222	0	0	0	0	0	0	0	0	23,222	22
23	Inservice Training & Education	0	0	727	0	0	0	0	0	0	0	0	727	23
24	Travel and Seminar	0	0	6,531	0	0	0	0	0	0	0	0	6,531	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	7,759	0	0	0	0	0	0	0	0	7,759	26
27	Other (specify):*	(25)	0	0	0	0	0	0	0	0	0	0	(25)	27
28	TOTAL General Administration	(12,155)	(150,988)	229,629	0	66,486	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(12,155)	(52,318)	251,252	0	186,779	29							

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Minonk# 0048058

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	94,918	0	6,828	0	0	0	0	0	0	0	101,746	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,367)	71,500	0	239	0	0	0	0	0	0	0	70,372	32
33	Real Estate Taxes	0	37,460	0	0	0	0	0	0	0	0	0	37,460	33
34	Rent-Facility & Grounds	(2,905)	(315,360)	0	4,467	0	0	0	0	0	0	0	(313,798)	34
35	Rent-Equipment & Vehicles	0	0	0	1,186	0	0	0	0	0	0	0	1,186	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,272)	(111,482)	0	12,720	0	(103,034)	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)	(16,427)	(163,800)	251,252	12,720	0	83,745	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
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. 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%	98,670	98,670	2
3	V							3
4	V	19 Adjustment for Related Organization	150,988	Heritage Operations Group, LLC	0.00%		(150,988)	4
5	V							5
6	V	34 Adjustment for Related Organization	315,360	Heritage Manor Real Estate, LLC	0.00%		(315,360)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		37,460	37,460	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		65,488	65,488	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		94,918	94,918	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		6,012	6,012	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 466,348			\$ 302,548	\$ * (163,800)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	2,808	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						1,438	19	
20	V	6 Maintenance						14,335	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						1,395	22	
23	V	10 Nursing & Medical Records						0	23	
24	V	11 Activities						625	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,021	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						8,805	31	
32	V	20 Fees, Subscription, Promotions						5,731	32	
33	V	21 Clerical & General Office Expenses						176,854	33	
34	V	22 Employee Benefits & Payroll Taxes						23,222	34	
35	V	23 Inservice Training & Education						727	35	
36	V	24 Travel and Seminar						6,531	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						7,759	38	
39	Total		\$			\$	0	\$ *	251,252	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	0 15
16	V	30 Depreciation						6,828 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						239 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						4,467 20
21	V	35 Rent-Equipment & Vehicles						1,186 21
22	V	36 Other						0 22
23	V	38 Medically Nec Transportation						0 23
24	V	39 Ancillary Service Centers						0 24
25	V	40 Barber and Beauty Shops						0 25
26	V	41 Coffee and Gift Shops						0 26
27	V	42 Other						0 27
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$	0	\$ * 12,720 39

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

Facility Name & ID Number Heritage Manor-Minonk # 0048058 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-Minonk

0048058

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 102,708	\$ 102,349	72	\$ 2,808	1
2	2	Food Purchase	Beds	2,634	25	29	0	72	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	72	0	3
4	4	Laundry	Beds	2,634	25	0	0	72	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	72	1,438	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	72	14,335	6
7	7	Other	Beds	2,634	25	0	0	72	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	72	1,395	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	72	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	72	625	10
11	12	Social Service	Beds	2,634	25	0	0	72	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	72	1,021	12
13	14	Program Transportation	Beds	2,634	25	0	0	72	0	13
14	15	Other	Beds	2,634	25	0	0	72	0	14
15	17	Administrative	Beds	2,634	25	0	0	72	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	72	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	72	8,805	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	72	5,731	18
19	21	Clerical & General Office Expens	Beds	2,634	25	6,469,900	6,230,337	72	176,854	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	72	23,222	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	72	727	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	72	6,531	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	72	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	72	7,759	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 251,252	25

Facility Name & ID Number Heritage Manor-Minonk

0048058

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	25	\$	72	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	72	6,828	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		72		3
4	32	Interest	Beds	2,634	25	8,747	72	239	4
5	33	Real Estate Taxes	Beds	2,634	25		72		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	72	4,467	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	72	1,186	7
8	36	Other	Beds	2,634	25		72		8
9	38	Medically Nec Transportation	Beds	2,634	25		72		9
10	39	Ancillary Service Centers	Beds	2,634	25		72		10
11	40	Barber and Beauty Shops	Beds	2,634	25		72		11
12	41	Coffee and Gift Shops	Beds	2,634	25		72		12
13	42	Other	Beds	2,634	25		72		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	\$		\$ 12,720	25

Facility Name & ID Number

Heritage Manor-Minonk

0048058

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Bank of America		xx	Mortgage			\$	\$ 933,403	03/11	variable	\$ 65,488	1						
2	Bank of America		xx	Loan Fees							6,012	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Bank of America		xx	Accounts Receivable							5,762	6						
7												7						
8												8						
9	TOTAL Facility Related						\$	\$ 933,403			\$ 77,262	9						
B. Non-Facility Related*																		
10	Interest Income										(1,367)	10						
11	Allocated Corporate										239	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (1,128)	14						
15	TOTALS (line 9+line14)						\$	\$ 933,403			\$ 76,134	15						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2008 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	37,460	2
3. Under or (over) accrual (line 2 minus line 1).		\$	37,460	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.		\$	37,460	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	35,421	8	
	2005	26,483	9	
	2006	34,546	10	
	2007	34,664	11	
	2008	37,460	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>37,460.00</u>	\$ <u>37,460.00</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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,560 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

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

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

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

NONE

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>25,000</u>	1
2					2
3	TOTALS			\$ <u>25,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	72			\$ 1,039,908	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	Smoke Detectors (45)		1998	3,267					9
10	Compressor		1998	1,047					10
11	Generator		1998	12,140					11
12	A/C Repair		1998	1,518					12
13	Plumbing Repair		1998	4,956					13
14									14
15	Water Heater		1996	2,603					15
16	Resident Room Renovating		1996	8,483					16
17	Exterior Painting & Renovation		1996	4,806					17
18	Nurse Call System		1996	3,803					18
19	Garbage Disposal		1996	867					19
20	Boiler Repair		1996	4,436					20
21	Receptionist Work Area Renovation		1996	1,260					21
22	Hot Water Heater		1996	505					22
23	Exterior Signage		1996	1,680					23
24	Interior Rehab		1996	146,288					24
25	Interior Rehab		1996	22,963					25
26	Code Alert System		1996	1,319					26
27									27
28	Interior Rehab		1997	33,578					28
29	Interior Rehab		1997	168					29
30	Building Purchase Offset		1997	(141,199)					30
31									31
32									32
33									33
34	C/O Allocation						6,828	6,828	34
35	Book Depreciation				69,494		69,494		592,127
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-Minonk

0048058

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	Door Alarm System	1999	\$ 10,116	\$		\$	\$	\$	37
38	Plumbing / Water Heater	1999	3,170						38
39	Sewage Ejector	1999	3,042						39
40									40
41	Water Heater	2000	3,293						41
42	Remove and replace patio	2000	5,890						42
43									43
44	Garbage Disposal	2001	922						44
45	Painting--Hallways/Resident rooms	2001	2,444						45
46									46
47	Water Faucet	2002	1,656						47
48	Boiler	2002	17,945						48
49	Shower Faucet	2002	2,398						49
50									50
51	Roof	2003	30,757						51
52	Faucets	2003	1,915						52
53	Compressor	2003	1,126						53
54	Disposal	2003	970						54
55									55
56	Water Heater	2004	3,889						56
57	Hot Water Storage Tank	2004	1,744						57
58	Ansul System	2004	1,455						58
59	Door Alarm System	2004	10,914						59
60	Heat Exchanger	2004	1,518						60
61									61
62	Sewage Ejector	2005	3,310						62
63	Circulator Motor	2005	892						63
64	Dry Valve	2005	2,410						64
65	Integrety Bather	2005							65
66	Exterior Doors	2005	6,106						66
67	Sprinkler Repair	2005	2,957						67
68	Glass Door	2005							68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,275,235	\$ 69,494		\$ 76,322	\$ 6,828	\$ 592,127	70

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

Facility Name & ID Number Heritage Manor-Minonk

0048058

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		\$ 1,275,235	\$ 69,494		\$ 76,322	\$ 6,828	\$ 592,127	1
2	Climate Control	2006	1,299						2
3	Shower Faucet	2006	444						3
4	Sprinkler main line	2006	6,672						4
5	Compressor	2006	1,580						5
6	Corridor Rehab	2006	5,855						6
7	Rooftop A/C	2006	8,235						7
8	Audit ADJ 2006	2006	(1,227)						8
9	Fire Alarm	2007	39,698						9
10	Chiller	2007	11,569						10
11	Bearing Assembly	2007	1,109						11
12	Sprinkler	2007	2,180						12
13	HVAC	2007	876						13
14	Landscaping	2007	9,585						14
15	Thermostat	2007	7,722						15
16	Audit ADJ 2007	2007	(6,433)						16
17	Nurse Call System	2008	125,184						17
18	Soffit & Facia	2008	14,880						18
19	Water Heater	2008	9,193						19
20	Wonderguard	2008	8,777						20
21	Wireless phone system	2008	22,250						21
22	Cables for Nurse Call system	2008	9,897						22
23									23
24	Shower Faucet	2009	6,569						24
25	Front Doors	2009	6,370						25
26	Sprinkler System	2009	43,180						26
27	Water Heater	2009	7,017						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,617,716	\$ 69,494		\$ 76,322	\$ 6,828	\$ 592,127	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 263,046	\$ 25,424	\$ 25,424	\$		\$ 219,530	71
72	Current Year Purchases	8,053						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 271,099	\$ 25,424	\$ 25,424	\$		\$ 219,530	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		Van	2008	\$ 61,815	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 61,815	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,975,630	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,918	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,746	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,828	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 811,657	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

16. Rental Amount for movable equipment: \$ 1,768 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		240		240
3	Classroom Wages (a)				
4	Clinical Wages (b)		3,711		3,711
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 3,951	\$	\$ 3,951
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,951		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 114,947	\$		\$ 114,947	1
2	Licensed Speech and Language Development Therapist		hrs				7,094			7,094	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				105,614	850		106,464	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts					196,434		196,434	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						10,902			10,902	13
14	TOTAL			\$			\$ 238,557	\$ 197,284		\$ 435,841	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-Minonk# 0048058Report 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	\$ 355	\$	1
2	Cash-Patient Deposits	5,513		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	224,470		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,451		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(78,545)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 155,244	\$	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)	\$ 155,244	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 95,498	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,513		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,148		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,183		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)	\$ 232,342	\$	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)	\$ 232,342	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (77,098)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 155,244	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (80,471)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (80,471)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,373	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)	\$ 3,373	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)	\$ (77,098)	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,240,801	1
2	Discounts and Allowances for all Levels	(1,037,756)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,203,045	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	803,936	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 803,936	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	222	12
13	Barber and Beauty Care	2,163	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,905	16
17	Sale of Drugs	344,885	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,706	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 361,881	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,367	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,367	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)	\$ 3,370,229	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	692,411	31
32	Health Care	1,571,848	32
33	General Administration	779,568	33
B. Capital Expense			
34	Ownership	322,890	34
C. Ancillary Expense			
35	Special Cost Centers	139	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,366,856	40
41	Income before Income Taxes (line 30 minus line 40)**	3,373	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,373	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-Minonk

0048058

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	1,968	2,160	\$ 61,193	\$ 28.33	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	6,879	7,757	187,690	24.20	3
4	Licensed Practical Nurses	7,574	7,968	172,286	21.62	4
5	CNAs & Orderlies	41,531	45,389	540,766	11.91	5
6	CNA Trainees	350	350	3,711	10.60	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	118	140	2,705	19.32	8
9	Activity Director					9
10	Activity Assistants	3,085	3,346	59,215	17.70	10
11	Social Service Workers	1,609	2,097	36,824	17.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,954	20,434	203,635	9.97	15
16	Dishwashers					16
17	Maintenance Workers	3,957	4,199	56,511	13.46	17
18	Housekeepers	1,896	4,970	73,649	14.82	18
19	Laundry	4,755	5,159	46,320	8.98	19
20	Administrator	1,900	2,080	81,846	39.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,848	6,483	103,564	15.97	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)	100,424	112,532	\$ 1,629,915 *	\$ 14.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	889		36
37	Medical Records Consultant	1,760		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,160		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	1,937		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 6,746		49

C. CONTRACT NURSES

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

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

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

Facility Name & ID Number Heritage Manor-Minonk# 0048058Report Period Beginning: 01/01/2009Ending: 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 Minonk 38364 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 26,828
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.