

Facility Name & ID Number Heritage Manor-Streator

0048066 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	130	Skilled (SNF)	130	47,450	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	130	TOTALS	130	47,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	24,881	13,814	5,559	44,254	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,881	13,814	5,559	44,254	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.26%

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 5,559

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-Streator # 0048066 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	363,463	22,903		386,366		386,366	5,069	391,435		1
2	Food Purchase		140,305		140,305		140,305	1	140,306		2
3	Housekeeping	140,057	22,548		162,605		162,605		162,605		3
4	Laundry	57,398	26,223		83,621		83,621		83,621		4
5	Heat and Other Utilities			166,344	166,344		166,344	2,596	168,940		5
6	Maintenance	95,018	86,205	52,276	233,499		233,499	25,883	259,382		6
7	Other (specify):*										7
8	TOTAL General Services	655,936	298,184	218,620	1,172,740		1,172,740	33,549	1,206,289		8
	B. Health Care and Programs										
9	Medical Director			1,400	1,400		1,400	2,519	3,919		9
10	Nursing and Medical Records	2,515,060	204,385	17,724	2,737,169		2,737,169		2,737,169		10
10a	Therapy		347,157	557,827	904,984	(387,368)	517,616	283,424	801,040		10a
11	Activities	79,891	5,385		85,276		85,276	1,128	86,404		11
12	Social Services	32,450	60	2,643	35,153		35,153		35,153		12
13	CNA Training	15,758	3,372		19,130		19,130	1,844	20,974		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,643,159	560,359	579,594	3,783,112	(387,368)	3,395,744	288,915	3,684,659		16
	C. General Administration										
17	Administrative	99,414			99,414		99,414		99,414		17
18	Directors Fees										18
19	Professional Services			348,402	348,402		348,402	(332,504)	15,898		19
20	Dues, Fees, Subscriptions & Promotions			112,450	112,450	(71,175)	41,275	(12,892)	28,383		20
21	Clerical & General Office Expenses	172,507	24,557	6,432	203,496		203,496	319,319	522,815		21
22	Employee Benefits & Payroll Taxes			709,638	709,638		709,638	41,928	751,566		22
23	Inservice Training & Education			4,013	4,013		4,013	1,313	5,326		23
24	Travel and Seminar			15,738	15,738		15,738	11,792	27,530		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			65,216	65,216		65,216	14,010	79,226		26
27	Other (specify):*			7,730	7,730		7,730	(7,580)	150		27
28	TOTAL General Administration	271,921	24,557	1,269,619	1,566,097	(71,175)	1,494,922	35,386	1,530,308		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,571,016	883,100	2,067,833	6,521,949	(458,543)	6,063,406	357,850	6,421,256		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-Streator

#0048066

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 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							251,956	251,956			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,283	15,283		15,283	224,075	239,358			32
33	Real Estate Taxes							59,268	59,268			33
34	Rent-Facility & Grounds			525,600	525,600		525,600	(517,534)	8,066			34
35	Rent-Equipment & Vehicles			7,758	7,758		7,758	2,142	9,900			35
36	Other (specify):*											36
37	TOTAL Ownership			548,641	548,641		548,641	19,907	568,548			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					387,368	387,368		387,368			39
40	Barber and Beauty Shops			20,843	20,843		20,843		20,843			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					71,175	71,175		71,175			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			20,843	20,843	458,543	479,386		479,386			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,571,016	883,100	2,637,317	7,091,433		7,091,433	377,757	7,469,190			45

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

Heritage Manor-Streator

ID# 0048066

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		(780)	20	17
18				18
19			24	19
20		(1,580)	27	20
21				21
22		(2,275)	19	22
23				23
24		(6,000)	27	24
25		(22,459)	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	(33,094)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Streator# 0048066

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	5,069	0	0	0	0	0	0	0	0	5,069	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	2,596	0	0	0	0	0	0	0	0	2,596	5
6	Maintenance	0	0	25,883	0	0	0	0	0	0	0	0	25,883	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	33,549	0	0	0	0	0	0	0	0	33,549	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,519	0	0	0	0	0	0	0	0	2,519	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	283,424	0	0	0	0	0	0	0	0	0	283,424	10a
11	Activities	0	0	1,128	0	0	0	0	0	0	0	0	1,128	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,844	0	0	0	0	0	0	0	0	1,844	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	283,424	5,491	0	0	0	0	0	0	0	0	288,915	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	(2,275)	(346,127)	15,898	0	0	0	0	0	0	0	0	(332,504)	19
20	Fees, Subscriptions & Promotions	(23,239)	0	10,347	0	0	0	0	0	0	0	0	(12,892)	20
21	Clerical & General Office Expenses	0	0	319,319	0	0	0	0	0	0	0	0	319,319	21
22	Employee Benefits & Payroll Taxes	0	0	41,928	0	0	0	0	0	0	0	0	41,928	22
23	Inservice Training & Education	0	0	1,313	0	0	0	0	0	0	0	0	1,313	23
24	Travel and Seminar	0	0	11,792	0	0	0	0	0	0	0	0	11,792	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	14,010	0	0	0	0	0	0	0	0	14,010	26
27	Other (specify):*	(7,580)	0	0	0	0	0	0	0	0	0	0	(7,580)	27
28	TOTAL General Administration	(33,094)	(346,127)	414,607	0	0	0	0	0	0	0	0	35,386	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(33,094)	(62,703)	453,647	0	0	0	0	0	0	0	0	357,850	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Streator# 0048066

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	239,628	0	12,328	0	0	0	0	0	0	0	251,956	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,043)	230,686	0	432	0	0	0	0	0	0	0	224,075	32
33	Real Estate Taxes	0	59,268	0	0	0	0	0	0	0	0	0	59,268	33
34	Rent-Facility & Grounds	0	(525,600)	0	8,066	0	0	0	0	0	0	0	(517,534)	34
35	Rent-Equipment & Vehicles	0	0	0	2,142	0	0	0	0	0	0	0	2,142	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,043)	3,982	0	22,968	0	19,907	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(40,137)	(58,721)	453,647	22,968	0	0	0	0	0	0	0	377,757	45

Facility Name & ID Number

Heritage Manor-Streator

0048066

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.

YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization		GreenTree Pharmacy	0.00%	283,424	283,424	2
3	V							3
4	V	19 Adjustment for Related Organization	346,127	Heritage Operations Group, LLC	0.00%		(346,127)	4
5	V							5
6	V	34 Adjustment for Related Organization	525,600	Heritage Manor Real Estate, LLC	0.00%		(525,600)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		59,268	59,268	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		219,729	219,729	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		239,628	239,628	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		10,957	10,957	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 871,727			\$ 813,006	\$ * (58,721)	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%	\$	\$	5,069 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						2,596 19
20	V	6 Maintenance						25,883 20
21	V	7 Other						0 21
22	V	9 Medical Director						2,519 22
23	V	10 Nursing & Medical Records						0 23
24	V	11 Activities						1,128 24
25	V	12 Social Service						0 25
26	V	13 Nurse Aide Training						1,844 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						15,898 31
32	V	20 Fees, Subscription, Promotions						10,347 32
33	V	21 Clerical & General Office Expenses						319,319 33
34	V	22 Employee Benefits & Payroll Taxes						41,928 34
35	V	23 Inservice Training & Education						1,313 35
36	V	24 Travel and Seminar						11,792 36
37	V	25 Other Admin. Staff Transportation						0 37
38	V	26 Insurance-Prop.Liab.Malpract						14,010 38
39	Total		\$			\$	0	\$ * 453,647 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						12,328	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						432	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						8,066	20	
21	V	35 Rent-Equipment & Vehicles						2,142	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	* 22,968	39

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

Facility Name & ID Number Heritage Manor-Streator # 0048066 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-Streator# 0048066

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Heritage Operations Group

Street Address

box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

()

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 102,708	\$ 102,349	130	\$ 5,069	1
2	2	Food Purchase	Beds	2,634	25	29	0	130	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	130	0	3
4	4	Laundry	Beds	2,634	25	0	0	130	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	130	2,596	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	130	25,883	6
7	7	Other	Beds	2,634	25	0	0	130	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	130	2,519	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	130	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	130	1,128	10
11	12	Social Service	Beds	2,634	25	0	0	130	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	130	1,844	12
13	14	Program Transportation	Beds	2,634	25	0	0	130	0	13
14	15	Other	Beds	2,634	25	0	0	130	0	14
15	17	Administrative	Beds	2,634	25	0	0	130	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	130	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	130	15,898	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	130	10,347	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	130	319,319	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	130	41,928	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	130	1,313	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	130	11,792	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	130	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	130	14,010	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 453,647	25

Facility Name & ID Number Heritage Manor-Streator

0048066

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	25	\$	130	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	130	12,328	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		130		3
4	32	Interest	Beds	2,634	25	8,747	130	432	4
5	33	Real Estate Taxes	Beds	2,634	25		130		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	130	8,066	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	130	2,142	7
8	36	Other	Beds	2,634	25		130		8
9	38	Medically Nec Transportation	Beds	2,634	25		130		9
10	39	Ancillary Service Centers	Beds	2,634	25		130		10
11	40	Barber and Beauty Shops	Beds	2,634	25		130		11
12	41	Coffee and Gift Shops	Beds	2,634	25		130		12
13	42	Other	Beds	2,634	25		130		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	\$	\$ 22,968	25

Facility Name & ID Number

Heritage Manor-Streator

0048066

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America		xx	Mortgage			\$	\$ 3,207,969	03/11	variable	\$ 219,729	1							
2	Bank of America		xx	Loan Fees							10,957	2							
3												3							
4												4							
5												5							
Working Capital																			
6	Bank of America		xx	Accounts Receivable							15,283	6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$ 3,207,969			\$ 245,969	9							
B. Non-Facility Related*																			
10	Interest Income										(7,043)	10							
11	Allocated Corporate										432	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (6,611)	14							
15	TOTALS (line 9+line14)						\$	\$ 3,207,969			\$ 239,358	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.)

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-Streator COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048066

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>3431134000</u>	<u>nursing home</u>	\$ <u>59,268.00</u>	\$ <u>59,268.00</u>
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>59,268.00</u>	\$ <u>59,268.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number Heritage Manor-Streator

0048066

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,262 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

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

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

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

NONE

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>17,000</u>	1
2					2
3	TOTALS			\$ <u>17,000</u>	3

Facility Name & ID Number Heritage Manor-Streator

0048066

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	130			\$ 348,848	\$		\$	\$	\$
5				440,122					
6				2,594,839					
7									
8									
	Improvement Type**								
9	1978 Improvements	1980		12,172					
10	1979 Improvements	1981		13,748					
11	1980 Improvements	1982		18,366					
12	1981 Improvements	1983		9,250					
13	1982 Improvements	1984		1,329					
14	1983 Improvements	1985		4,100					
15	1984 Improvements	1986		57,336					
16	1985 Improvements	1987		6,225					
17	1986 Improvements	1988		48,818					
18	1988 Improvements	1989		22,687					
19	1989 Improvements	1990		31,584					
20	1990 Improvements	1991		3,560					
21	1991 Improvements	1992		19,172					
22	1992 Improvements	1993		23,135					
23	1993 Improvements	1994		22,036					
24	1994 Improvements	1995		39,228					
25	1995 Improvements	1996		3,910					
26	BOILER								
27	EXHAUST HOOD								
28	CODE ALERT								
29	PHONE SYSTEM								
30	INTERIOR REMODEL								
31									
32									
33									
34	C/O Allocation						12,328	12,328	
35	Book Depreciation				162,231		162,231		1,288,812
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-Streator# 0048066

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	Interior Rehab---Facility	1997	\$ 286,974	\$		\$	\$	\$	37
38	Roof	1997	5,232						38
39	Sprinkler System	1997	9,530						39
40	Code Alert	1997	1,879						40
41									41
42	Code Alert	1998	2,000						42
43	Bathroom Door	1998	656						43
44	Interior Rehab	1998	11,815						44
45									45
46	Door Alarms	1999	3,675						46
47									47
48	Water Heater	2000	4,114						48
49	Exhaust Fans	2000	931						49
50	Booster Heater -- Water Heater	2000	1,465						50
51									51
52	Professional Fees---Building Renovation	2001	27,964						52
53	Sprinkler Replacement	2001	4,955						53
54	AC Unit with Installation	2001	4,372						54
55	Exterior Painting	2001	6,545						55
56	Code Alert System	2001	4,592						56
57									57
58	Roof	2002	48,840						58
59	Sewer line	2002	20,615						59
60	Condensing Unit	2002	1,213						60
61									61
62	Exterior Door	2003	6,556						62
63	Exit Lights	2003	1,013						63
64	Heating Pump	2003	1,746						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,177,147	\$ 162,231		\$ 174,559	\$ 12,328	\$ 1,288,812	70

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

Facility Name & ID Number Heritage Manor-Streator# 0048066

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		\$ 4,177,147	\$ 162,231		\$ 174,559	\$ 12,328	\$ 1,288,812	1
2	Doors	2004	1,386						2
3	A/C	2004	5,061						3
4	PVC kickplate	2004	2,859						4
5	Disposal	2004	1,175						5
6									6
7	Roof	2005	54,596						7
8	A/C Condensing Unit	2005	5,800						8
9	Window Replacement	2005	51,893						9
10	Water Main	2005	1,706						10
11									11
12									12
13	Roof	2006	19,500						13
14	A/C Replacement	2006	1,974						14
15	Boiler	2006	58,327						15
16	Landscapping	2006	5,398						16
17									17
18	Nurse's station	2007	9,580						18
19	Nurse call system	2007	96,193						19
20	Wireless network	2007	26,272						20
21	Corridor Paint and floors	2007	37,819						21
22	A/C	2007	23,747						22
23	Wander guard	2007	4,177						23
24	Garage --Construction of new Maintenance Garage	2007	42,453						24
25	Professional Fee -- remodel	2007	1,286						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,628,349	\$ 162,231		\$ 174,559	\$ 12,328	\$ 1,288,812	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 4,628,349	\$ 162,231		\$ 174,559	\$ 12,328	\$ 1,288,812	1
2	2008	22,238						2
3	2008	9,644						3
4	2008	63,040						4
5	2008	10,301						5
6	2008	8,101						6
7								7
8	2009	4,035						8
9	2009	2,752						9
10	2009	22,230						10
11								11
12								12
13								13
14								14
15								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		\$ 4,770,690	\$ 162,231		\$ 174,559	\$ 12,328	\$ 1,288,812	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	\$ 1,137,157	\$ 77,397	\$ 77,397	\$		\$ 884,428	71
72	Current Year Purchases	23,822						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,160,979	\$ 77,397	\$ 77,397	\$		\$ 884,428	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)	\$ 5,948,669	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 239,628	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 251,956	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,328	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,173,240	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 7,758 Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		3,372		3,372
3	Classroom Wages (a)				
4	Clinical Wages (b)		15,758		15,758
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 19,130	\$	\$ 19,130
10	SUM OF line 9, col. 1 and 2 (e)	\$	19,130		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 224,655	\$		\$ 224,655	1
2	Licensed Speech and Language Development Therapist		hrs			39,214			39,214	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			250,597	3,150		253,747	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				344,007		344,007	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					43,361			43,361	13
14	TOTAL			\$		\$ 557,827	\$ 347,157		\$ 904,984	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-Streator# 0048066Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 19,854	\$	1
2	Cash-Patient Deposits	9,482		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	704,285		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,713		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	77		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 765,411	\$	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)	\$ 765,411	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 179,776	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,482		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	369,591		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,395		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)	\$ 563,244	\$	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)	\$ 563,244	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 202,167	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 765,411	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (447,932)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (447,932)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	650,099	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)	\$ 650,099	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)	\$ 202,167	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Streator# 0048066Report Period Beginning: 01/01/2009Ending: 12/31/2009

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,599,215	1
2	Discounts and Allowances for all Levels	(2,223,821)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,375,394	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,714,051	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,714,051	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,544	12
13	Barber and Beauty Care	30,257	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	602,056	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,381	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 642,238	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,043	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,043	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other	2,806	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,806	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,741,532	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,172,740	31
32	Health Care	3,783,112	32
33	General Administration	1,566,097	33
B. Capital Expense			
34	Ownership	548,641	34
C. Ancillary Expense			
35	Special Cost Centers	20,843	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)*	\$ 7,091,433	40
41	Income before Income Taxes (line 30 minus line 40)**	650,099	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 650,099	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-Streator**

0048066

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	1,871	2,085	\$ 64,652	\$ 31.01	1
2	Assistant Director of Nursing	1,748	2,080	55,998	26.92	2
3	Registered Nurses	13,218	13,872	379,435	27.35	3
4	Licensed Practical Nurses	22,819	24,753	588,167	23.76	4
5	CNAs & Orderlies	107,629	115,773	1,399,092	12.08	5
6	CNA Trainees	1,600	1,600	15,758	9.85	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,218	2,376	27,716	11.66	8
9	Activity Director					9
10	Activity Assistants	6,508	7,288	79,891	10.96	10
11	Social Service Workers	1,932	2,076	32,450	15.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,839	36,680	363,463	9.91	15
16	Dishwashers					16
17	Maintenance Workers	6,575	7,085	95,018	13.41	17
18	Housekeepers	14,784	15,561	140,057	9.00	18
19	Laundry	5,318	5,807	57,398	9.88	19
20	Administrator	1,900	2,080	99,414	47.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,703	10,791	172,507	15.99	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)	232,662	249,907	\$ 3,571,016 *	\$ 14.29	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		1,400		36
37	Medical Records Consultant		3,700		37
38	Nurse Consultant				38
39	Pharmacist Consultant		0		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		2,643		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 7,743		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heritage Manor-Streator# 0048066Report 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 Streator 38349 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 71,175
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.