

Facility Name & ID Number Heritage Nursing Home

0038620 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 N/A

	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	44	Skilled (SNF)	44	16,060	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	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	Private Pay	4 Other	Total	
8	SNF	4,888	377	1,226	6,491	8
9	SNF/PED					9
10	ICF	32,030	622		32,652	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,918	999	1,226	39,143	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.78%

D. How many bed-hold days during this year were paid by the Department?

87 (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 11/01/92

J. Was the facility purchased or leased after January 1, 1978?

YES Date 11/01/92 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 21 and days of care provided 1,226

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number Heritage Nursing Home # 0038620 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	198,428	11,812	5,280	215,520		215,520		215,520		1
2	Food Purchase		182,806		182,806	(24,455)	158,351	(720)	157,631		2
3	Housekeeping	120,823	21,970		142,793		142,793		142,793		3
4	Laundry	45,102	9,348	1,913	56,363		56,363		56,363		4
5	Heat and Other Utilities			101,314	101,314		101,314		101,314		5
6	Maintenance	44,762	5,418	23,020	73,200		73,200		73,200		6
7	Other (specify):*			11,931	11,931		11,931		11,931		7
8	TOTAL General Services	409,115	231,354	143,458	783,927	(24,455)	759,472	(720)	758,752		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,310,490	40,192	30,617	1,381,299		1,381,299		1,381,299		10
10a	Therapy	22,869			22,869		22,869		22,869		10a
11	Activities	85,844		5,728	91,572		91,572	(952)	90,620		11
12	Social Services	38,334	2,837	5,786	46,957		46,957		46,957		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,457,537	43,029	54,131	1,554,697		1,554,697	(952)	1,553,745		16
	C. General Administration										
17	Administrative	194,739		318,000	512,739		512,739	(218,988)	293,751		17
18	Directors Fees										18
19	Professional Services			36,431	36,431		36,431	600	37,031		19
20	Dues, Fees, Subscriptions & Promotions			32,608	32,608		32,608	(18,063)	14,545		20
21	Clerical & General Office Expenses	140,868	28,479	17,311	186,658		186,658	(74,319)	112,339		21
22	Employee Benefits & Payroll Taxes			355,798	355,798	24,455	380,253		380,253		22
23	Inservice Training & Education			1,239	1,239		1,239		1,239		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			1,798	1,798		1,798	(1,756)	42		25
26	Insurance-Prop.Liab.Malpractice			466	466		466	109,087	109,553		26
27	Other (specify):*			36,191	36,191		36,191	(29,632)	6,559		27
28	TOTAL General Administration	335,607	28,479	799,842	1,163,928	24,455	1,188,383	(233,071)	955,312		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,202,259	302,862	997,431	3,502,552		3,502,552	(234,743)	3,267,809		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,280
	REPAIRS & MAINTENANCE	0
		0
		5,280
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,913
		0
		1,913
5	HEAT & OTHER UTILITIES	
	GAS HEAT	47,033
	ELECTRICITY	36,061
	WATER	18,152
	CABLE TV - LOBBY	68
		0
		101,314
6	MAINTENANCE	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	805
	BUILDING REPAIRS	14,650
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	3,230
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,335
	FIRE SERVICE	0
		0
		0
		0
		0
		23,020
7	OTHER	
	SCAVENGER	11,931
	SECURITY SERVICE	0
		0
		0
		11,931
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	12,000
		12,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	25,161
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,536
	PHARMACY CONSULTANT XVIII B 39-2	3,920
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		30,617
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	952
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	4,776
		0
		5,728
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	5,786
	SOCIAL WORKER XVIII B 45-2	0
		0
		5,786
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

LINE	SCHED REF	TOTAL
V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER		
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	318,000
		318,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
		0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	11,558
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	24,873
		0
		36,431
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	3,709
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	10,041
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	2,050
	DUES & SUBSCRIPTIONS XIX F	9,750
	LICENSES & PERMITS XIX F	3,295
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	2,263
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	585
	PATIENT BACKGROUND CHECKS XIX F	915
		0
		32,608
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	3,349
	EQUIPMENT REPAIR & MAINTENANCE	180
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	20
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	13,762
	MESSENGER SERVICE	0
		0
		17,311

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	167,084
	UNEMPLOYMENT COMPENSATION XIX D	20,182
	WORKERS COMPENSATION INSURANC XIX D	37,145
	HOSPITALIZATION INSURANCE XIX D	100,881
	EMPLOYEE BENEFITS - OTHER XIX D	9,999
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	16,367
	CHICAGO HEAD TAX XIX D	4,140
		0
		355,798
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,239
		0
		1,239
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,798
		0
		1,798
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	466
		0
		466
27	OTHER	
	BAD DEBTS VI 24	36,191
		0
		36,191

GRAND TOTAL COLUMN 3 OTHER

997,431

Heritage Nursing Home
SCHEDULES
12/31/2009

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	182,806	
LESS SALES TAX	<u>(720)</u>	HAVE YOU FORGOTTEN TO EN
NET FOOD	182,086	
TOTAL PATIENT CENSUS	39,143	
TIME 3 MEALS PER DAY	<u>3</u>	
TOTAL PATIENT MEALS	117,429	
ADD # EMPLOYEE MEALS/DAY	50	
TIME # DAYS	<u>365</u>	
TOTAL EMPLOYEE MEALS	18,250	
PATIENT MEALS	117,429	
ADD EMPLOYEE MEALS	<u>18,250</u>	
TOTAL MEALS/YEAR	135,679	
NET FOOD	182,086	
DIVIDE TOTAL MEALS/YEAR	<u>135,679</u>	
COST PER MEAL	1.34	
TIME EMPLOYEE MEALS	<u>18,250</u>	
EMPLOYEE MEAL RECLASSIFICATION	24,455	
	=====	

INTER SALES TAX ON PAGE 5??

Facility Name & ID Number

Heritage Nursing Home

#0038620

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			43,395	43,395		43,395	56,967	100,362		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			6,878	6,878		6,878	184,900	191,778		32
33	Real Estate Taxes							136,098	136,098		33
34	Rent-Facility & Grounds			559,456	559,456		559,456	(559,456)			34
35	Rent-Equipment & Vehicles			427	427		427		427		35
36	Other (specify):*							15,248	15,248		36
37	TOTAL Ownership			610,156	610,156		610,156	(166,243)	443,913		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		55,970	101,271	157,241		157,241		157,241		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			70,080	70,080		70,080		70,080		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers		55,970	171,351	227,321		227,321		227,321		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,202,259	358,832	1,778,938	4,340,029		4,340,029	(400,986)	3,939,043		45

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

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	(952)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(292)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(720)	2		13
14	Non-Care Related Interest	(1,091)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20)	21		18
19	Entertainment	(3,709)	20		19
20	Contributions	(4,313)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,191)	27		24
25	Fund Raising, Advertising and Promotional	(10,041)	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	(76,199)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (133,528)		\$	30

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)	(267,458)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (267,458)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (400,986)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

Heritage Nursing Home

ID# 0038620

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	MARKETING SALARY	(74,443)	21	2
3	MARKETING TRAVEL	(1,756)	25	3
4				4
5				5
6				6
7				7
8				8
9				9
10				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				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	(76,199)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Nursing Home# 0038620

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(720)	0	0	0	0	0	0	0	0	0	0	(720)	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(720)	0	0	0	0	0	0	0	0	0	0	(720)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(952)	0	0	0	0	0	0	0	0	0	0	(952)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	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	(952)	0	0	0	0	0	0	0	0	0	0	(952)	16
	C. General Administration													
17	Administrative	0	0	(218,988)	0	0	0	0	0	0	0	0	(218,988)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	600	0	0	0	0	0	0	0	0	0	600	19
20	Fees, Subscriptions & Promotions	(18,063)	0	0	0	0	0	0	0	0	0	0	(18,063)	20
21	Clerical & General Office Expenses	(74,463)	0	144	0	0	0	0	0	0	0	0	(74,319)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,756)	0	0	0	0	0	0	0	0	0	0	(1,756)	25
26	Insurance-Prop.Liab.Malpractice	0	109,087	0	0	0	0	0	0	0	0	0	109,087	26
27	Other (specify):*	(36,191)	0	6,559	0	0	0	0	0	0	0	0	(29,632)	27
28	TOTAL General Administration	(130,473)	109,687	(212,285)	0	(233,071)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(132,145)	109,687	(212,285)	0	(234,743)	29							

STATE OF ILLINOIS

Facility Name & ID Number Heritage Nursing Home# 0038620

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	56,967	0	0	0	0	0	0	0	0	0	56,967	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,383)	186,283	0	0	0	0	0	0	0	0	0	184,900	32
33	Real Estate Taxes	0	136,098	0	0	0	0	0	0	0	0	0	136,098	33
34	Rent-Facility & Grounds	0	(559,456)	0	0	0	0	0	0	0	0	0	(559,456)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	15,248	0	0	0	0	0	0	0	0	0	15,248	36
37	TOTAL Ownership	(1,383)	(164,860)	0	(166,243)	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)	(133,528)	(55,173)	(212,285)	0	0	0	0	0	0	0	0	(400,986)	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
Dan Shabat	100%	Waterford Nursing & Rehabilitation Centre	Chicago	Heritage Healthcare Center LLC		Building Co
				Pharmore Drugs LLC		Drug Co
				Lifescan Laboratory Inc		Lab Co
				SFMA Inc		Mgmt Co
				Pro Health Care Inc		Mgmt Co

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)		
1	V	34 Rent	\$ 559,456	Heritage Healthcare Center LLC	100.00%	\$	\$	(559,456)	1
2	V	32 Interest	528	Heritage Healthcare Center LLC				(528)	2
3	V								3
4	V	32 Interest		Heritage Healthcare Center LLC		182,989		182,989	4
5	V	19 Professional Fees		Heritage Healthcare Center LLC		600		600	5
6	V	26 Insurance Expense		Heritage Healthcare Center LLC		109,087		109,087	6
7	V	36 MIP Insurance		Heritage Healthcare Center LLC		15,248		15,248	7
8	V	33 R E Taxes		Heritage Healthcare Center LLC		136,098		136,098	8
9	V	30 Depreciation		Heritage Healthcare Center LLC		56,967		56,967	9
10	V	32 Interest Mortgage Cost		Heritage Healthcare Center LLC		3,822		3,822	10
11	V								11
12	V								12
13	V								13
14	Total		\$ 559,984			\$ 504,811	\$ *	(55,173)	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	17 Management Fees	\$ 312,000	SFMA INC	100.00%	\$	\$ (312,000)
16	V	17 Dan Shabat Comp		SFMA INC		97,500	97,500
17	V	21 Office		SFMA INC		144	144
18	V	27 Admin Benefits		SFMA INC		6,421	6,421
19	V						
20	V						
21	V	17 Management Fees	6,000	Pro Health Care Inc	100.00%		(6,000)
22	V	17 Salary - Stan Aron		Pro Health Care Inc		1,512	1,512
23	V	27 Payroll Taxes		Pro Health Care Inc		138	138
24	V						
25	V						
26	V	10 In House Drugs	4,882	Pharmore Drugs LLC	100.00%	4,882	
27	V	39 Medicare - Drugs	51,485	Pharmore Drugs LLC		51,485	
28	V	10 Pharmacy Consultant	3,920	Pharmore Drugs LLC		3,920	
29	V						
30	V						
31	V	39 Medicare - Laboratory	1,499	Lifescan Laboratory Inc	26.00%	1,499	
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 379,786			\$ 167,501	\$ * (212,285)

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

Facility Name & ID Number

Heritage Nursing Home

0038620

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	Dan Shabat	Owner	Administrative	100.00	See Attached	20	33.33	Alloc Salary	\$ 97,500	17-7	1
2	Stan Aron		Administrative		See Attached	2	4.65	Alloc Salary	1,512	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 99,012		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 Nursing Home

0038620

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					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Heritage Nursing Home

0038620

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		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1	Heartland Bank		X	Mortgage	\$18,972.78	08/25/06	\$ 3,164,500	\$ 3,029,214	09/01/36	6.0000	\$ 182,989	1								
2	HUD		X	Mortgage Costs		08/25/06	114,655	101,915	09/01/36		3,822	2								
3												3								
4												4								
5												5								
	Working Capital																			
6	Bank Financial		X	Line of Credit					05/22/10	4.5000	5,787	6								
7												7								
8												8								
9	TOTAL Facility Related				\$18,972.78		\$ 3,279,155	\$ 3,131,129			\$ 192,598	9								
	B. Non-Facility Related*																			
10	IRS, IDR, ETC		X	LATE FEES							1,091	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 1,091	14								
15	TOTALS (line 9+line14)						\$ 3,279,155	\$ 3,131,129			\$ 193,689	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 15,248 Line # 36

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

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

Facility Name & ID Number Heritage Nursing Home

0038620

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 84,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

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>Facility</u>		<u>1991</u>	<u>\$ 105,600</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 105,600	3

Facility Name & ID Number Heritage Nursing Home

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	128	1991	1971	\$ 1,878,400	\$ 48,164	39	\$ 48,164		\$ 913,111	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	BUILDING:									9
10	Heritage Nursing Center Inc		1983	6,069		15			6,069	10
11	Heritage Nursing Center Inc		1984	2,054		10			2,054	11
12	Heritage Nursing Center Inc		1985	3,700		10			3,700	12
13	Heritage Nursing Center Inc		1985	5,594		10			5,594	13
14	Heritage Nursing Center Inc		1986	5,000		10			5,000	14
15	Heritage Nursing Center Inc		1987	2,250		10			2,250	15
16	Heritage Nursing Center Inc		1988	6,084		10			6,084	16
17	Heritage Nursing Center Inc		1990	4,919		10			4,919	17
18	Heritage Nursing Center Inc		1991	118,564		10			118,564	18
19	Heritage Nursing Center Inc		1991	6,809		10			6,809	19
20	Heritage Nursing Center Inc		1992	12,811		10			12,811	20
21	Heritage Nursing Center Inc		1992	8,947		10			8,947	21
22	Heritage Nursing Center Inc		2007	43,252	4,325	10	4,325		10,898	22
23	Heritage Nursing Center Inc		2007	392	78	5	78		189	23
24	Heritage Nursing Center Inc		2007	21,260	1,418	15	1,418		3,308	24
25	Heritage Nursing Center Inc		2007	14,908	2,982	5	2,982		6,957	25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Nursing Home# 0038620

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			\$	\$		\$	\$	\$	37
38	FACILITY:								38
39	Various	1993	22,988		15			22,988	39
40	Various	1994	22,000	1,100	20	1,100		16,751	40
41	Various	1994	19,790	454	15	454		19,790	41
42	Various	1995	3,300	220	15	220		3,227	42
43	Various	1995	1,640		10			1,640	43
44	Various	1995	59,530	2,978	20	2,978		42,806	44
45	Various	1996	83,406	4,170	20	4,170		57,442	45
46	Various	1997	4,851		7			4,851	46
47	Various	1997	25,361	1,268	20	1,268		16,326	47
48	Various	2000	5,357	43	20	43		4,902	48
49	Various	2002	13,354	1,335	10	1,335		10,340	49
50	Various	2004	33,850	3,385	10	3,385		17,489	50
51									51
52	Wallcoverings and Flooring	2005	85,222	5,682	15	5,682		23,144	52
53	Install Water Coils	2005	21,675	4,335	5	4,335		18,424	53
54	Paint and Custom Replacement Baseboard Covers	2007	1,803	361	5	361		782	54
55	Nurses Station	2007	3,790	379	10	379		821	55
56	1st, 2nd and 3rd Floor Nurses Stations	2007	10,000	1,000	10	1,000		2,333	56
57	Nurses Station Sprinkler Head Improvements	2007	2,207	221	10	221		478	57
58	Barker Metalcraft	2008	1,803	180	10	180		285	58
59	Doors Done Right - Door, Frame and Heavy Duty Closer	2008	2,181	145	15	145		230	59
60	Walkin Cooler/Freezer	2008	20,505	4,101	20	4,101		5,126	60
61	Install Walkin Cooler/Freezer	2009	10,791	2,158	5	2,158		2,158	61
62	Cable Hardware & installation Resident & Day Rooms	2009	10,850	995	10	995		995	62
63	Repair Elevator Door	2009	8,675	315	27.5	315		315	63
64	Fire Alarm & Sprinkler System Repairs	2009	3,202	107	27.5	107		107	64
65	Hot Water Coil & Boiler Repairs	2009	5,693	74	27.5	74		74	65
66	"LG" Mini Split System For Kitchen	2009	5,029	91	27.5	91		91	66
67	Replace Front East Gate	2009	1,950	35	27.5	35		35	67
68	Steel Frame & Door	2009	1,891	17	27.5	17		17	68
69	Electrical Work & Motors for Exhaust Fans	2009	4,080	65	27.5	65		65	69
70	TOTAL (lines 4 thru 69)		\$ 2,637,787	\$ 92,181		\$ 92,181	\$	\$ 1,391,296	70

**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	\$ 84,022	\$ 7,938	\$ 7,938	\$	5 - 10 Yrs	\$ 69,042	71
72	Current Year Purchases	2,917	243	243		5 - 10 Yrs	243	72
73	Fully Depreciated Assets	218,661				5 - 10 Yrs	218,661	73
74	<u>Heritage Nursing Center Inc</u>	<u>246,855</u>				5 - 10 Yrs	<u>246,855</u>	74
75	TOTALS	\$ 552,455	\$ 8,181	\$ 8,181	\$		\$ 534,801	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,295,842	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 100,362	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 100,362	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,926,097	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: N/A

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: \$ 427 Description: POSTAGE METER RENTAL

(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 checked="" 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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 41,643	\$		\$ 41,643	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			812			812	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			58,816			58,816	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				53,993		53,993	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>LABS, MED SUPPLY</u>	39-2					1,977		1,977	13
14	TOTAL			\$		\$ 101,271	\$ 55,970		\$ 157,241	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 Nursing Home# 0038620Report 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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 13,302	\$ 87,508	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>327,908</u>)	715,483	715,483	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,386	72,662	6
7	Other Prepaid Expenses	7,254	7,254	7
8	Accounts Receivable (owners or related parties)	748,787	748,787	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,501,212	\$ 1,631,694	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,600	13
14	Buildings, at Historical Cost		1,878,400	14
15	Leasehold Improvements, at Historical Cost	496,774	714,990	15
16	Equipment, at Historical Cost	305,603	596,854	16
17	Accumulated Depreciation (book methods)	(561,974)	(1,923,580)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		526,719	21
22	Other Long-Term Assets (spe <u>Mortgage Costs</u>)		101,915	22
23	Other(specify): <u>Security Deposit</u>	5,000	5,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 245,403	\$ 2,005,898	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,746,615	\$ 3,637,592	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 249,503	\$ 283,211	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,705	6,705	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,530	92,530	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,624	23,624	31
32	Accrued Real Estate Taxes(Sch.IX-B)		138,761	32
33	Accrued Interest Payable		15,146	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Related Parties</u>	669,926	1,058,438	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,042,288	\$ 1,618,415	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,029,214	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)	\$	\$ 3,029,214	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,042,288	\$ 4,647,629	46
47	TOTAL EQUITY (page 18, line 24)	\$ 704,327	\$ (1,010,037)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,746,615	\$ 3,637,592	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 706,420	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 706,419	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,092)	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)	\$ (2,092)	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)	\$ 704,327	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Nursing Home# 0038620Report 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	\$ 4,545,849	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,545,849	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	60,625	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 60,625	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	292	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 292	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,606,766	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	783,927	31
32	Health Care	1,554,697	32
33	General Administration	1,163,928	33
B. Capital Expense			
34	Ownership	610,156	34
C. Ancillary Expense			
35	Special Cost Centers	157,241	35
36	Provider Participation Fee	70,080	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES	268,829	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,608,858	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,092)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,092)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** 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 Nursing Home**

0038620

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	1,856	2,072	\$ 77,395	\$ 37.35	1
2	Assistant Director of Nursing	1,840	2,088	62,651	30.01	2
3	Registered Nurses	7,446	7,832	197,004	25.15	3
4	Licensed Practical Nurses	16,673	17,781	425,678	23.94	4
5	CNAs & Orderlies	37,857	46,737	434,094	9.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,699	1,912	22,869	11.96	8
9	Activity Director	1,813	2,145	24,668	11.50	9
10	Activity Assistants	5,598	6,459	61,176	9.47	10
11	Social Service Workers	1,843	2,083	38,334	18.40	11
12	Dietician					12
13	Food Service Supervisor	1,888	2,154	34,399	15.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,505	17,155	164,029	9.56	15
16	Dishwashers					16
17	Maintenance Workers	2,531	2,762	44,762	16.21	17
18	Housekeepers	11,414	14,302	120,823	8.45	18
19	Laundry	4,082	4,895	45,102	9.21	19
20	Administrator	1,912	2,080	65,508	31.49	20
21	Assistant Administrator					21
22	Other Administrative	1,992	2,240	129,231	57.69	22
23	Office Manager					23
24	Clerical	6,461	7,016	140,868	20.08	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	1,767	1,995	18,528	9.29	31
32	Other Health C: <u>Psycho Soc, MDS</u>	6,630	7,546	95,140	12.61	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,807	151,254	\$ 2,202,259 *	\$ 14.56	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	M	\$ 5,280	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	1,536	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,920	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,776	11-3	44
45	Social Service Consultant	E	5,786	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,298		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	32	\$ 1,404	10-3	50
51	Licensed Practical Nurses	639	23,757	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	671	\$ 25,161		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Thomas Dean	ADMINISTRATOR		\$ 65,508	Workers' Compensation Insurance	\$ 37,145	IDPH License Fee	\$	
Sylvia Herlihy	OTHER ADMIN		129,231	Unemployment Compensation Insurance	20,182	Advertising: Employee Recruitment	0	
				FICA Taxes	167,084	Health Care Worker Background Check	585	
				Employee Health Insurance	100,881	(Indicate # of checks performed 24)		
				Employee Meals	24,455	Patient Background Checks	37 915	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	4,313	
				EMPLOYEE BENEFITS - OTHER	9,999	MARKETING/ADV/PROMO	13,750	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	13,045	
				PENSION/PROFIT SHARING PLANS	16,367	MGMT CO ALLOC		
				CHICAGO HEAD TAX	4,140	TRUST/FRANCHISE/CONTRIB/ETC	(4,313)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(3,709)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(10,041)	
						Yellow page advertising	(0)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 194,739	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 380,253		\$ 14,545		
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - SFMA			\$ 312,000				Out-of-State Travel	\$
Management Fees - Pro Health			6,000					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 318,000				Seminar Expense	0
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 36,431	TOTAL		\$	TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	0	\$	\$	\$	\$								

Facility Name & ID Number Heritage Nursing Home

0038620

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICLTC \$7,951 IL ASSOC HEALTH CARE \$1,536
- (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? N/A
- (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? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 730 Line 10-2
- (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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 70,080
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. \$ 24,455 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? NO
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A
- (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.