



Facility Name & ID Number Heritage Manor-Gillespie

# 0048892 Report Period Beginning: 1-01-10 Ending: 12-31-10

**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	118	Skilled (SNF)	118	43,070	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	118	TOTALS	118	43,070	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,331	9,274	3,229	28,834	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,331	9,274	3,229	28,834	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.95%**

**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 07/2007

**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 3,229

Medicare Intermediary WPS

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

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

Facility Name &amp; ID Number

Heritage Manor-Gillespie

# 0048892

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	184,140	9,799		193,939		193,939	4,702	198,641		1
2	Food Purchase		179,055		179,055		179,055	(1,111)	177,944		2
3	Housekeeping	81,369	17,451		98,820		98,820		98,820		3
4	Laundry	41,231	10,790		52,021		52,021		52,021		4
5	Heat and Other Utilities			107,806	107,806		107,806	2,032	109,838		5
6	Maintenance	63,402	56,943	44,639	164,984		164,984	14,002	178,986		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	370,142	274,038	152,445	796,625		796,625	19,625	816,250		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,817	15,817		15,817	3,454	19,271		9
10	Nursing and Medical Records	1,360,725	68,871	15,135	1,444,731		1,444,731		1,444,731		10
10a	Therapy		223,808	390,774	614,582	(251,549)	363,033	163,494	526,527		10a
11	Activities	53,780	3,051		56,831		56,831	4	56,835		11
12	Social Services	32,746	31	2,923	35,700		35,700		35,700		12
13	CNA Training	2,164			2,164		2,164	1,559	3,723		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,449,415	295,761	424,649	2,169,825	(251,549)	1,918,276	168,511	2,086,787		16
	<b>C. General Administration</b>										
17	Administrative	87,025			87,025		87,025	99,894	186,919		17
18	Directors Fees										18
19	Professional Services			208,193	208,193		208,193	(186,297)	21,896		19
20	Dues, Fees, Subscriptions & Promotions			118,458	118,458	(64,605)	53,853	(29,800)	24,053		20
21	Clerical & General Office Expenses	140,591	25,145	9,823	175,559		175,559	204,482	380,041		21
22	Employee Benefits & Payroll Taxes			369,105	369,105		369,105	37,520	406,625		22
23	Inservice Training & Education			3,012	3,012		3,012	(1,013)	1,999		23
24	Travel and Seminar			1,727	1,727		1,727	272	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			52,180	52,180		52,180	13,422	65,602		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	227,616	25,145	762,498	1,015,259	(64,605)	950,654	138,480	1,089,134		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,047,173	594,944	1,339,592	3,981,709	(316,154)	3,665,555	326,616	3,992,171		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 &amp; ID Number

Heritage Manor-Gillespie

#0048892

Report Period Beginning:

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Ending:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							208,093	208,093			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,589	8,589		8,589	218,439	227,028			32
33	Real Estate Taxes							30,181	30,181			33
34	Rent-Facility & Grounds			516,840	516,840		516,840	(509,024)	7,816			34
35	Rent-Equipment & Vehicles			12,384	12,384		12,384	1,433	13,817			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			537,813	537,813		537,813	(50,878)	486,935			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					251,549	251,549		251,549			39
40	Barber and Beauty Shops		374	13,663	14,037		14,037		14,037			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					64,605	64,605		64,605			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		374	13,663	14,037	316,154	330,191		330,191			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,047,173	595,318	1,891,068	4,533,559		4,533,559	275,738	4,809,297			45

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

Facility Name & ID Number Heritage Manor-Gillespie

# 0048892

Report Period Beginning:

1-01-10

Ending:

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**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(4,875)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)	(1,452)	23		16
17	Non-Care Related Fees	(1,800)	20		17
18	Fines and Penalties				18
19	Entertainment	(9,152)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(465)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(40,095)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (57,839)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	333,577		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 333,577		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ 275,738		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.**

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

Heritage Manor-Gillespie

ID# 0048892

Report Period Beginning: 1-01-10

Ending: 12-31-10

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

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	(1,800)	20	17
18			18
19		24	19
20	0	27	20
21			21
22	(465)	19	22
23			23
24	0	27	24
25	(40,095)	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	(42,360)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Gillespie# 0048892 Report Period Beginning:

1-01-10

Ending:

12-31-10

## 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	4,702	0	0	0	0	0	0	0	0	4,702	1
2	Food Purchase	0	0	(1,111)	0	0	0	0	0	0	0	0	(1,111)	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	2,032	0	0	0	0	0	0	0	0	2,032	5
6	Maintenance	0	0	14,002	0	0	0	0	0	0	0	0	14,002	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>19,625</b>	<b>0</b>	<b>19,625</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	3,454	0	0	0	0	0	0	0	0	3,454	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	163,494	0	0	0	0	0	0	0	0	0	163,494	10a
11	Activities	0	0	4	0	0	0	0	0	0	0	0	4	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,559	0	0	0	0	0	0	0	0	1,559	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>163,494</b>	<b>5,017</b>	<b>0</b>	<b>168,511</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	99,894	0	0	0	0	0	0	0	0	99,894	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(465)	(206,228)	20,396	0	0	0	0	0	0	0	0	(186,297)	19
20	Fees, Subscriptions & Promotions	(41,895)	0	12,095	0	0	0	0	0	0	0	0	(29,800)	20
21	Clerical & General Office Expenses	0	0	204,482	0	0	0	0	0	0	0	0	204,482	21
22	Employee Benefits & Payroll Taxes	0	0	37,520	0	0	0	0	0	0	0	0	37,520	22
23	Inservice Training & Education	(1,452)	0	439	0	0	0	0	0	0	0	0	(1,013)	23
24	Travel and Seminar	(9,152)	0	9,424	0	0	0	0	0	0	0	0	272	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	13,422	0	0	0	0	0	0	0	0	13,422	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(52,964)</b>	<b>(206,228)</b>	<b>397,672</b>	<b>0</b>	<b>138,480</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(52,964)</b>	<b>(42,734)</b>	<b>422,314</b>	<b>0</b>	<b>326,616</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number

Heritage Manor-Gillespie

# 0048892

Report Period Beginning:

1-01-10

Ending:

12-31-10

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	196,869	0	11,224	0	0	0	0	0	0	0	208,093	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,875)	222,602	0	712	0	0	0	0	0	0	0	218,439	32
33	Real Estate Taxes	0	30,116	0	65	0	0	0	0	0	0	0	30,181	33
34	Rent-Facility & Grounds	0	(516,840)	0	7,816	0	0	0	0	0	0	0	(509,024)	34
35	Rent-Equipment & Vehicles	0	0	0	1,433	0	0	0	0	0	0	0	1,433	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(4,875)</b>	<b>(67,253)</b>	<b>0</b>	<b>21,250</b>	<b>0</b>	<b>(50,878)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(57,839)</b>	<b>(109,987)</b>	<b>422,314</b>	<b>21,250</b>	<b>0</b>	<b>275,738</b>	<b>45</b>						

Facility Name & ID Number

Heritage Manor-Gillespie

# 0048892

Report Period Beginning:

1-01-10

Ending:

12-31-10

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:	
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		\$			\$		1
2	V	10a Adjustment for Related Organization		GreenTree Pharmacy	0.00%	163,494	163,494	2
3	V							3
4	V	19 Adjustment for Related Organization	206,228	Heritage Operations Group, LLC	0.00%		(206,228)	4
5	V							5
6	V	34 Adjustment for Related Organization	516,840	Heritage Manor Real Estate, LLC	0.00%		(516,840)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		30,116	30,116	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		217,711	217,711	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		196,869	196,869	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		4,891	4,891	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 723,068			\$ 613,081	\$ * (109,987)	14

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

Facility Name &amp; ID Number

Heritage Manor-Gillespie

# 0048892

Report Period Beginning:

1-01-10

Ending:

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## 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.		\$	\$ 4,702	15
16	V	2 Food Purchase					(1,111)	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					2,032	19
20	V	6 Maintenance					14,002	20
21	V	7 Other					0	21
22	V	9 Medical Director					3,454	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					4	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,559	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					99,894	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					20,396	31
32	V	20 Fees, Subscription, Promotions					12,095	32
33	V	21 Clerical & General Office Expenses					204,482	33
34	V	22 Employee Benefits & Payroll Taxes					37,520	34
35	V	23 Inservice Training & Education					439	35
36	V	24 Travel and Seminar					9,424	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					13,422	38
39	Total		\$			\$	0	\$ * 422,314 39

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

Facility Name & ID Number

Heritage Manor-Gillespie

# 0048892

Report Period Beginning:

1-01-10

Ending:

12-31-10

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 15
16	V	30	Depreciation						11,224 16
17	V	31	Amortization of Pre-Op & Org						0 17
18	V	32	Interest						712 18
19	V	33	Real Estate Taxes						65 19
20	V	34	Rent-Facility & Grounds						7,816 20
21	V	35	Rent-Equipment & Vehicles						1,433 21
22	V	36	Other						0 22
23	V	38	Medically Nec Transportation						0 23
24	V	39	Ancillary Service Centers						0 24
25	V	40	Barber and Beauty Shops						0 25
26	V	41	Coffee and Gift Shops						0 26
27	V	42	Other						0 27
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			\$	0	\$ * 21,250 39

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

Facility Name &amp; ID Number

Heritage Manor-Gillespie

#

0048892

Report Period Beginning:

1-01-10

Ending:

12-31-10

## 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-Gillespie

# 0048892

Report Period Beginning:

1-01-10

Ending: 12-31-10

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 Heritage Operations Group  
 Street Address box 3188  
 City / State / Zip Code Bloomington, IL 61701  
 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	Dietary	Beds	2,634	25	\$ 104,969	\$ 104,969	118	\$ 4,702	1
2	2	Food Purchase	Beds	2,634	25	(24,794)	0	118	(1,111)	2
3	3	Housekeeping	Beds	2,634	25	0	0	118	0	3
4	4	Laundry	Beds	2,634	25	0	0	118	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	45,364	0	118	2,032	5
6	6	Maintenance	Beds	2,634	25	312,555	75,007	118	14,002	6
7	7	Other	Beds	2,634	25	0	0	118	0	7
8	9	Medical Director	Beds	2,634	25	77,111	0	118	3,454	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	77,111	118	0	9
10	11	Activities	Beds	2,634	25	95	0	118	4	10
11	12	Social Service	Beds	2,634	25	0	0	118	0	11
12	13	Nurse Aide Training	Beds	2,634	25	34,804	0	118	1,559	12
13	14	Program Transportation	Beds	2,634	25	0	0	118	0	13
14	15	Other	Beds	2,634	25	0	0	118	0	14
15	17	Administrative	Beds	2,634	25	2,229,831	2,229,831	118	99,894	15
16	18	Directors Fees	Beds	2,634	25	0	0	118	0	16
17	19	Professional Services	Beds	2,634	25	455,276	0	118	20,396	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	269,994	0	118	12,095	18
19	21	Clerical & General Office Expens	Beds	2,634	25	4,564,447	4,163,572	118	204,482	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	837,533	0	118	37,520	20
21	23	Inservice Training & Education	Beds	2,634	25	9,793	0	118	439	21
22	24	Travel and Seminar	Beds	2,634	25	210,373	0	118	9,424	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	118	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	299,608	0	118	13,422	24
25	TOTALS					\$ 9,426,959	\$ 6,650,490		\$ 422,314	25

Facility Name & ID Number Heritage Manor-Gillespie

# 0048892

Report Period Beginning:

1-01-10

Ending: 12-31-10

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	\$	118	\$	1
2	30	Depreciation	Beds	2,634	25	250,538	118	11,224	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		118		3
4	32	Interest	Beds	2,634	25	15,900	118	712	4
5	33	Real Estate Taxes	Beds	2,634	25	1,448	118	65	5
6	34	Rent-Facility & Grounds	Beds	2,634	25	174,472	118	7,816	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	31,994	118	1,433	7
8	36	Other	Beds	2,634	25		118		8
9	38	Medically Nec Transportation	Beds	2,634	25		118		9
10	39	Ancillary Service Centers	Beds	2,634	25		118		10
11	40	Barber and Beauty Shops	Beds	2,634	25		118		11
12	41	Coffee and Gift Shops	Beds	2,634	25		118		12
13	42	Other	Beds	2,634	25		118		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					\$ 474,352	\$	\$ 21,250	25

**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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Bank of America		xx	Mortgage			\$	\$ 3,522,563	3/2011	variable	\$ 217,711	1							
2	Bank of America		xx	Loan Fees							4,891	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Bank of America		xx	Accounts Receivable							8,589	6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$	\$ 3,522,563			\$ 231,191	9							
<b>B. Non-Facility Related*</b>																			
10	Interest Income										(4,875)	10							
11	Allocated Corporate										712	11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (4,163)	14							
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 3,522,563			\$ 227,028	15							

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

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2009 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>30,116</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>30,116</b>	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>30,116</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	<b>34,009</b>	8
	2006	<b>26,573</b>	9
	2007	<b>29,430</b>	10
	2008	<b>29,468</b>	11
	2009	<b>30,116</b>	12

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**2009 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor-Gillespie COUNTY Macoupin  
 FACILITY IDPH LICENSE NUMBER 0048892  
 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 2009 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 2009.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>1000040001</u>	<u>nursing home</u>	\$ <u>30,024.00</u>	\$ <u>30,024.00</u>
2. <u>1000278402</u>	<u></u>	\$ <u>92.00</u>	\$ <u>92.00</u>
3. <u></u>	<u></u>	\$ _____	\$ _____
4. <u></u>	<u></u>	\$ _____	\$ _____
5. <u></u>	<u></u>	\$ _____	\$ _____
6. <u></u>	<u></u>	\$ _____	\$ _____
7. <u></u>	<u></u>	\$ _____	\$ _____
8. <u></u>	<u></u>	\$ _____	\$ _____
9. <u></u>	<u></u>	\$ _____	\$ _____
10. <u></u>	<u></u>	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>30,116.00</u></u>	\$ <u><u>30,116.00</u></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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

**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-Gillespie

# 0048892 Report Period Beginning:

1-01-10 Ending:

12-31-10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 14,677 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

NONE

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 27,045	1
2					2
3	TOTALS			\$ 27,045	3

Facility Name & ID Number Heritage Manor-Gillespie# 0048892

Report Period Beginning:

1-01-10

Ending:

12-31-10**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	118				\$ 3,578,055	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Roof Repair		1997		2,275						9
10	Storage Tank		1997		1,857						10
11											11
12	Heritage Manor Sign		1996		1,896						12
13	Laundry Room A/C		1996		3,019						13
14											14
15	Garbage Disposal		1998		730						15
16	Roof		1998		90,404						16
17											17
18	Water Heater		1999		3,596						18
19	Air Conditioning Unit		1999		1,145						19
20	Smoke Dampers/Fire Alarm Replacement		1999		5,802						20
21	Interior Painting--Materials and Labor		1999		2,459						21
22	Roof		1999		29,985						22
23											23
24	Interior Painting--Materials and Labor		2000		3,923						24
25											25
26	Booster Heater		2001		1,903						26
27	Telephone System Add-on		2001		62						27
28											28
29	A/C Rooftop Unit		2002		2,703						29
30											30
31											31
32											32
33	C/O Allocation							11,224	11,224		33
34	Book Depreciation					147,680		147,680			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 Manor-Gillespie# 0048892

Report Period Beginning:

1-01-10

Ending:

12-31-10**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	
37 A/C Units	2003	\$ 8,858	\$		\$	\$	\$	37
38 Asphalt Sealing	2003	2,408						38
39 Ansul System --Kitchen	2003	1,465						39
40								40
41 Front Door	2004	3,893						41
42 Heat Cool Unit	2004	4,522						42
43								43
44 Windows	2005	6,255						44
45 HVAC	2005	10,675						45
46 Rooftop A/C	2005	6,663						46
47 Parking Lot Sealer	2005	2,358						47
48 Wallcoverings	2005	597						48
49 Sidewalks	2005	4,444						49
50 Floor Replacement	2005	18,756						50
51 Boiler	2005	6,388						51
52								52
53 A/C Units	2006	6,865						53
54 Rooftop A/C	2006	8,234						54
55 Five Ton Condensing Unit	2006	2,980						55
56 Pump	2006							56
57 Exterior Door	2006							57
58 Boiler	2006	5,396						58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,830,571	\$ 147,680		\$ 158,904	\$ 11,224	\$	70

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

Facility Name & ID Number Heritage Manor-Gillespie# 0048892

Report Period Beginning:

1-01-10

Ending:

12-31-10**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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,830,571	\$ 147,680		\$ 158,904	\$ 11,224	\$	1
2	<u>HVAC</u>	2007	3,430						2
3	<u>Steamer Install</u>	2007							3
4	<u>Corridor Remodel</u>	2007							4
5	<u>HVAC</u>	2007	3,024						5
6	<u>Sprinkler Heads</u>	2007	2,569						6
7	<u>Boiler</u>	2007	11,881						7
8	<u>Plumbing</u>	2007	2,949						8
9									9
10	<u>Facility Rehab -- Paint, flooring, lighting</u>	2008	227,268						10
11	<u>Exterior Door</u>	2008	4,150						11
12	<u>Boilers</u>	2008	16,293						12
13	<u>Nurse Call System</u>	2008	123,168						13
14	<u>Window Replacement</u>	2008	54,925						14
15	<u>Parking Lot</u>	2008	37,142						15
16	<u>Wireless System</u>	2008	10,017						16
17	<u>Cabling</u>	2008	5,785						17
18	<u>Alarm System</u>	2008	8,804						18
19									19
20	<u>Rehab: Paint, window treatments, paint &amp; labor</u>	2009	27,218						20
21	<u>Landscaping rock</u>	2009	4,501						21
22	<u>Rooftop A/C</u>	2009	8,678						22
23	<u>Sewer pump</u>	2009	9,150						23
24	<u>Nurse Call System</u>	2009	88,196						24
25									25
26	<u>Carpeting: conference room</u>	2010	2,929						26
27	<u>Relocate/Install data equipment</u>	2010	10,251						27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,492,899	\$ 147,680		\$ 158,904	\$ 11,224	\$	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		\$ 4,492,899	\$ 147,680		\$ 158,904	\$ 11,224		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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,492,899	\$ 147,680		\$ 158,904	\$ 11,224		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		\$ 4,492,899	\$ 147,680		\$ 158,904	\$ 11,224		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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,492,899	\$ 147,680		\$ 158,904	\$ 11,224		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	\$ 768,747	\$ 49,189	\$ 49,189	\$		\$	71
72	Current Year Purchases	60,452						72
73	Fully Depreciated Assets							73
74								74
75	<b>TOTALS</b>	\$ 829,199	\$ 49,189	\$ 49,189	\$		\$	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 5,349,143	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 196,869	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 208,093	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,224	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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	<b>TOTALS</b>	\$	\$	\$	91

**G. Construction-in-Progress**

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

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

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

Facility Name & ID Number

Heritage Manor-Gillespie

#

0048892

Report Period Beginning:

1-01-10

Ending: 12-31-10

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

Table with 8 columns: 1 Year Constructed, 2 Number of Beds, 3 Original Lease Date, 4 Rental Amount, 5 Total Years of Lease, 6 Total Years Renewal Option\*, 7. Rows include Original Building, Additions, and TOTAL.

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: \$ 12,384 Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

Table with 5 columns: 1 Use, 2 Model Year and Make, 3 Monthly Lease Payment, 4 Rental Expense for this Period, 5. Rows 17-21.

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

Table with 2 columns: Fiscal Year Ending, Annual Rent. Rows 12, 13, 14.

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		2,164		2,164
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 2,164	\$	\$ 2,164
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	2,164		

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 165,028	\$		\$ 165,028	1
2	Licensed Speech and Language Development Therapist		hrs				48,098			48,098	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				146,056	3,851		149,907	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					219,957		219,957	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						31,592			31,592	13
14	<b>TOTAL</b>			\$			\$ 390,774	\$ 223,808		\$ 614,582	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-Gillespie# 0048892Report Period Beginning: 1-01-10

Ending:

12-31-10

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 13,752	\$	1
2	Cash-Patient Deposits	6,724		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	196,512		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,335		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	206,120		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 437,443	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 437,443	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 121,213	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,724		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	228,533		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,902		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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 376,372	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 376,372	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 61,071	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 437,443	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(211,609)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(211,609)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>272,680</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>272,680</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>61,071</b>	<b>24</b> *

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

Facility Name &amp; ID Number Heritage Manor-Gillespie

# 0048892

Report Period Beginning:

1-01-10

Ending:

12-31-10

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,657,786	1
2	Discounts and Allowances for all Levels	(1,488,835)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,168,951</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,220,746	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,220,746</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	838	12
13	Barber and Beauty Care	17,516	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	393,089	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	224	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 411,667</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,875	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 4,875</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Other</b>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,806,239</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	796,625	31
32	Health Care	2,169,825	32
33	General Administration	1,015,259	33
<b>B. Capital Expense</b>			
34	Ownership	537,813	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	14,037	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,533,559</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>272,680</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 272,680</b>	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-Gillespie

# 0048892

Report Period Beginning:

1-01-10

Ending:

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**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	1,833	2,027	\$ 58,199	\$ 28.71	1
2	Assistant Director of Nursing	1,876	2,094	53,398	25.50	2
3	Registered Nurses	3,785	4,052	169,274	41.78	3
4	Licensed Practical Nurses	15,378	16,645	318,786	19.15	4
5	CNAs & Orderlies	57,123	61,467	728,942	11.86	5
6	CNA Trainees	10	10	2,164	216.40	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,439	1,962	32,126	16.37	8
9	Activity Director					9
10	Activity Assistants	4,314	4,805	53,780	11.19	10
11	Social Service Workers	1,933	2,090	32,746	15.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,363	17,714	184,140	10.40	15
16	Dishwashers					16
17	Maintenance Workers	2,313	2,508	63,402	25.28	17
18	Housekeepers	7,617	8,176	81,369	9.95	18
19	Laundry	3,881	4,330	41,231	9.52	19
20	Administrator	1,900	2,080	87,025	41.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,117	8,050	140,591	17.46	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)	126,882	138,010	\$ 2,047,173 *	\$ 14.83	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	15,817		36
37	Medical Records Consultant	4,947		37
38	Nurse Consultant			38
39	Pharmacist Consultant	7,080		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	2,923		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 30,767		49

**C. CONTRACT NURSES**

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



Facility Name & ID Number Heritage Manor-Gillespie

# 0048892

Report Period Beginning: 1-01-10

Ending:

12-31-10

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

**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 Gillespie 41517 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 64,605  
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? yes 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. \$ 1,304
- (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.