FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0048918

Facility Name: Barton W Stone-Jacksonville

Address: 873 Grove Street (Number) Jacksonville (City) 62650 (Zip Code)

County: Morgan

Telephone Number: (217)479-3400 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 07/2007

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-01-10 to 12-31-10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Craig L. Ater
(Title) Exec V.P. & CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	185	Skilled (SNF)	185	67,525	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	24	Sheltered Care (SC)	24	8,760	5
6		ICF/DD 16 or Less			6
7	209	TOTALS	209	76,285	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,891	23,731	6,074	59,696	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	1,095	3,644		4,739	12
13	DD 16 OR LESS					13
14	TOTALS	30,986	27,375	6,074	64,435	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.47%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

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

I. On what date did you start providing long term care at this location?
Date started 07/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified _____ and days of care provided 6,074

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

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

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	520,293	22,353		542,646		542,646	8,329	550,975			1
2	Food Purchase		399,018		399,018		399,018	(1,967)	397,051			2
3	Housekeeping	256,068	39,665		295,733		295,733		295,733			3
4	Laundry	125,521	18,673		144,194		144,194		144,194			4
5	Heat and Other Utilities			292,540	292,540		292,540	3,599	296,139			5
6	Maintenance	140,927	155,925	92,139	388,991		388,991	24,800	413,791			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,042,809	635,634	384,679	2,063,122		2,063,122	34,761	2,097,883			8
	B. Health Care and Programs											
9	Medical Director			5,400	5,400		5,400	6,119	11,519			9
10	Nursing and Medical Records	3,653,905	205,238	40,934	3,900,077		3,900,077		3,900,077			10
10a	Therapy		534,024	979,738	1,513,762	(597,098)	916,664	549,945	1,466,609			10a
11	Activities	134,018	5,227		139,245		139,245	8	139,253			11
12	Social Services	76,388		5,255	81,643		81,643		81,643			12
13	CNA Training	17,272	452		17,724		17,724	2,762	20,486			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,881,583	744,941	1,031,327	5,657,851	(597,098)	5,060,753	558,834	5,619,587			16
	C. General Administration											
17	Administrative	97,646			97,646		97,646	176,930	274,576			17
18	Directors Fees											18
19	Professional Services			510,551	510,551		510,551	(469,495)	41,056			19
20	Dues, Fees, Subscriptions & Promotions			147,743	147,743	(101,288)	46,455	2,589	49,044			20
21	Clerical & General Office Expenses	322,004	42,031	24,246	388,281		388,281	362,175	750,456			21
22	Employee Benefits & Payroll Taxes			969,504	969,504		969,504	66,456	1,035,960			22
23	Inservice Training & Education			7,318	7,318		7,318	(5,319)	1,999			23
24	Travel and Seminar			1,239	1,239		1,239	760	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			102,700	102,700		102,700	23,773	126,473			26
27	Other (specify):*			149	149		149		149			27
28	**TOTAL General Administration**	419,650	42,031	1,763,450	2,225,131	(101,288)	2,123,843	157,869	2,281,712			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,344,042	1,422,606	3,179,456	9,946,104	(698,386)	9,247,718	751,464	9,999,182			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Barton W Stone-Jacksonville #0048918 Report Period Beginning: 1-01-10 Ending: 12-31-10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							396,516	396,516			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,470	13,470		13,470	142,664	156,134			32
33	Real Estate Taxes							87,068	87,068			33
34	Rent-Facility & Grounds			1,038,060	1,038,060		1,038,060	(1,024,216)	13,844			34
35	Rent-Equipment & Vehicles			12,578	12,578		12,578	2,539	15,117			35
36	Other (specify):*											36
37	TOTAL Ownership			1,064,108	1,064,108		1,064,108	(395,429)	668,679			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					597,098	597,098		597,098			39
40	Barber and Beauty Shops		1,199	39,071	40,270		40,270		40,270			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					101,288	101,288		101,288			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,199	39,071	40,270	698,386	738,656		738,656			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,344,042	1,423,805	4,282,635	11,050,482		11,050,482	356,035	11,406,517			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 Barton W Stone-Jacksonville # 0048918 Report Period Beginning: 1-01-10 Ending: 12-31-10

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		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	(6,439)	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)	(6,096)	23		16
17	Non-Care Related Fees	(1,698)	20		17
18	Fines and Penalties				18
19	Entertainment	(15,932)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(33,438)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(17,136)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (80,739)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	436,774		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 436,774		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 356,035		37

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

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

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

Barton W Stone-Jacksonville

ID# 0048918

Report Period Beginning: 1-01-10

Ending: 12-31-10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(1,698)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(33,438)	19	22
23				23
24		0	27	24
25		(17,136)	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**	(52,272)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	8,329	0	0	0	0	0	0	0	0	8,329	1
2	Food Purchase	0	0	(1,967)	0	0	0	0	0	0	0	0	(1,967)	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	3,599	0	0	0	0	0	0	0	0	3,599	5
6	Maintenance	0	0	24,800	0	0	0	0	0	0	0	0	24,800	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	34,761	0	0	0	0	0	0	0	0	34,761	8
	B. Health Care and Programs													
9	Medical Director	0	0	6,119	0	0	0	0	0	0	0	0	6,119	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	549,945	0	0	0	0	0	0	0	0	0	549,945	10a
11	Activities	0	0	8	0	0	0	0	0	0	0	0	8	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	2,762	0	0	0	0	0	0	0	0	2,762	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	549,945	8,889	0	0	0	0	0	0	0	0	558,834	16
	C. General Administration													
17	Administrative	0	0	176,930	0	0	0	0	0	0	0	0	176,930	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(33,438)	(472,182)	36,125	0	0	0	0	0	0	0	0	(469,495)	19
20	Fees, Subscriptions & Promotions	(18,834)	0	21,423	0	0	0	0	0	0	0	0	2,589	20
21	Clerical & General Office Expenses	0	0	362,175	0	0	0	0	0	0	0	0	362,175	21
22	Employee Benefits & Payroll Taxes	0	0	66,456	0	0	0	0	0	0	0	0	66,456	22
23	Inservice Training & Education	(6,096)	0	777	0	0	0	0	0	0	0	0	(5,319)	23
24	Travel and Seminar	(15,932)	0	16,692	0	0	0	0	0	0	0	0	760	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	23,773	0	0	0	0	0	0	0	0	23,773	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(74,300)	(472,182)	704,351	0	0	0	0	0	0	0	0	157,869	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(74,300)	77,763	748,001	0	0	0	0	0	0	0	0	751,464	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 **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 D. Ownership	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)	
30	Depreciation	0	376,637	0	19,879	0	0	0	0	0	0	0	396,516	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,439)	147,841	0	1,262	0	0	0	0	0	0	0	142,664	32
33	Real Estate Taxes	0	86,953	0	115	0	0	0	0	0	0	0	87,068	33
34	Rent-Facility & Grounds	0	(1,038,060)	0	13,844	0	0	0	0	0	0	0	(1,024,216)	34
35	Rent-Equipment & Vehicles	0	0	0	2,539	0	0	0	0	0	0	0	2,539	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,439)	(426,629)	0	37,639	0	0	0	0	0	0	0	(395,429)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(80,739)	(348,866)	748,001	37,639	0	0	0	0	0	0	0	356,035	45

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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. [x] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	549,945	549,945	2
3	V								3
4	V	19	Adjustment for Related Organization	472,182	Heritage Operations Group, LLC	0.00%		(472,182)	4
5	V								5
6	V	34	Adjustment for Related Organization	1,038,060	Heritage Manor Real Estate, LLC	0.00%		(1,038,060)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		86,953	86,953	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		142,319	142,319	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		376,637	376,637	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,522	5,522	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,510,242			$ 1,161,376	$ * (348,866)	14

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.		$	$ 8,329	15
16	V	2	Food Purchase					(1,967)	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					3,599	19
20	V	6	Maintenance					24,800	20
21	V	7	Other					0	21
22	V	9	Medical Director					6,119	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					8	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					2,762	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					176,930	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					36,125	31
32	V	20	Fees, Subscription, Promotions					21,423	32
33	V	21	Clerical & General Office Expenses					362,175	33
34	V	22	Employee Benefits & Payroll Taxes					66,456	34
35	V	23	Inservice Training & Education					777	35
36	V	24	Travel and Seminar					16,692	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					23,773	38
39	Total			$			$ 0	$ * 748,001	39

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.		$	$ 0	15
16	V	30	Depreciation					19,879	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					1,262	18
19	V	33	Real Estate Taxes					115	19
20	V	34	Rent-Facility & Grounds					13,844	20
21	V	35	Rent-Equipment & Vehicles					2,539	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 37,639	39

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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 Barton W Stone-Jacksonville # 0048918 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,634	25	$ 104,969	$ 104,969	209	$ 8,329	1
2	2	Food Purchase	Beds	2,634	25	(24,794)	0	209	(1,967)	2
3	3	Housekeeping	Beds	2,634	25	0	0	209	0	3
4	4	Laundry	Beds	2,634	25	0	0	209	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	45,364	0	209	3,599	5
6	6	Maintenance	Beds	2,634	25	312,555	75,007	209	24,800	6
7	7	Other	Beds	2,634	25	0	0	209	0	7
8	9	Medical Director	Beds	2,634	25	77,111	0	209	6,119	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	77,111	209	0	9
10	11	Activities	Beds	2,634	25	95	0	209	8	10
11	12	Social Service	Beds	2,634	25	0	0	209	0	11
12	13	Nurse Aide Training	Beds	2,634	25	34,804	0	209	2,762	12
13	14	Program Transportation	Beds	2,634	25	0	0	209	0	13
14	15	Other	Beds	2,634	25	0	0	209	0	14
15	17	Administrative	Beds	2,634	25	2,229,831	2,229,831	209	176,930	15
16	18	Directors Fees	Beds	2,634	25	0	0	209	0	16
17	19	Professional Services	Beds	2,634	25	455,276	0	209	36,125	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	269,994	0	209	21,423	18
19	21	Clerical & General Office Expens	Beds	2,634	25	4,564,447	4,163,572	209	362,175	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	837,533	0	209	66,456	20
21	23	Inservice Training & Education	Beds	2,634	25	9,793	0	209	777	21
22	24	Travel and Seminar	Beds	2,634	25	210,373	0	209	16,692	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	209	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	299,608	0	209	23,773	24
25	TOTALS					$ 9,426,959	$ 6,650,490		$ 748,001	25

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	25	$	$	209	$	1
2	30	Depreciation	Beds	2,634	25	250,538		209	19,879	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25			209		3
4	32	Interest	Beds	2,634	25	15,900		209	1,262	4
5	33	Real Estate Taxes	Beds	2,634	25	1,448		209	115	5
6	34	Rent-Facility & Grounds	Beds	2,634	25	174,472		209	13,844	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	31,994		209	2,539	7
8	36	Other	Beds	2,634	25			209		8
9	38	Medically Nec Transportation	Beds	2,634	25			209		9
10	39	Ancillary Service Centers	Beds	2,634	25			209		10
11	40	Barber and Beauty Shops	Beds	2,634	25			209		11
12	41	Coffee and Gift Shops	Beds	2,634	25			209		12
13	42	Other	Beds	2,634	25			209		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	$		$ 37,639	25

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 Report Period Beginning: 1-01-10 Ending: 12-31-10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		xx	Mortgage			$	$ 3,339,667	3/2011	variable	$ 142,319	1
2	Bank of America		xx	Loan Fees							5,522	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							13,470	6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,339,667			$ 161,311	9
	B. Non-Facility Related*											
10	Interest Income										(6,439)	10
11	Allocated Corporate										1,262	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,177)	14
15	TOTALS (line 9+line14)						$	$ 3,339,667			$ 156,134	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.)**

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 Report Period Beginning: 1-01-10 Ending: 12-31-10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)	$	86,953	2
3. Under or (over) accrual (line 2 minus line 1).	$	86,953	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. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	86,953	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	86,524	8
	2006	82,361	9
	2007	79,630	10
	2008	84,129	11
	2009	86,953	12

FOR BHF USE ONLY

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 Barton W Stone-Jacksonville COUNTY Morgan

FACILITY IDPH LICENSE NUMBER 0048918

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	0920308003	nursing home	$ 114,412.00	$ 86,953.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 114,412.00	$ 86,953.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 Barton W Stone-Jacksonville # 0048918 Report Period Beginning: 1-01-10 Ending: 12-31-10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,102 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

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

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

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

NONE

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	209				$ 3,295,725	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Facility Sign			2005	1,050						9
10	Dietary cabinets			2005	5,864						10
11	Ansul system			2005	1,600						11
12	Heat detectors			2005	1,777						12
13	Door system			2005	17,554						13
14	A/C units			2005	10,456						14
15	Thurnbury door			2005	1,593						15
16	Computer wiring			2005	1,280						16
17	A/C compressor			2005	2,849						17
18	Shelter care remodel-- paint, flooring, wallpaper			2006	225,040						18
19	landscapping			2006	2,262						19
20	Boiler			2006	2,580						20
21	Heat/cool units			2006	9,517						21
22	Fire alarm			2006	2,097						22
23	Roof			2006	145,352						23
24	Door system			2006	414						24
25	Mixing Valve			2006	5,060						25
26	Hutton Hall remodel (Shelter Care) -- Window treatments, painting			2006	31,147						26
27	sump pump			2006	2,001						27
28											28
29											29
30											30
31											31
32											32
33	C/O Allocation							19,879	19,879		33
34	Book Depreciation					210,780		210,780			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 Barton W Stone-Jacksonville # 0048918 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Backflow preventer	2007	$ 3,501	$		$	$	$	37
38	Shower/faucet	2007	875						38
39	Air Handler	2007	5,215						39
40	HVAC	2007	20,152						40
41	Tree removal	2007	9,491						41
42	Valance	2007	581						42
43	Younkin corridor remodel -- paint	2007	16,420						43
44	Trane compressor	2007	2,841						44
45	Elevator	2007							45
46	Parking lot	2007							46
47	Door alarm	2007							47
48	fire dampers	2007							48
49	concrete pad	2007							49
50	Sprinkler system	2007							50
51									51
52	Nurse Call System	2008	206,839						52
53	Mechanical systems	2008	12,996						53
54	Condensing Unit	2008	17,965						54
55	Laundry plumbing	2008	12,671						55
56	Heat / Cool units	2008	24,201						56
57	Fire Panel	2008	7,378						57
58	Water Heater	2008	5,272						58
59	Kitchen Air Handler	2008	26,187						59
60	Condensing Unit	2008	4,069						60
61	Wireless Phone system	2008	44,744						61
62	Cables-nurse call	2008	22,788						62
63	Resident Phones	2008	10,081						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,219,485	$ 210,780		$ 230,659	$ 19,879	$	70

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,219,485	$ 210,780		$ 230,659	$ 19,879	$	1
2	Compressor	2009	2,516						2
3	Condensing Unit	2009	16,946						3
4	Boiler Replacement	2009	10,434						4
5	Roof	2009	8,393						5
6	HVAC units	2009	5,735						6
7	Firewall	2009	6,951						7
8	HVAC units	2009	5,106						8
9	Laundry plumbing	2009	7,351						9
10	Sewer ejector	2009	5,189						10
11	Dinning room paint, flooring & labor	2009	55,148						11
12	Cabling	2009	10,874						12
13	Laundry plumbing	2009	7,015						13
14									14
15	Roof Repair	2010	10,654						15
16	heat/cool units	2010	11,449						16
17	Driveway sealant	2010	3,800						17
18	Wanderguard	2010	3,099						18
19	Furnace	2010	4,095						19
20	Carpet	2010	3,523						20
21	Dinning room paint, flooring & labor	2010	53,752						21
22	Boiler Replacement	2010	25,619						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)		$ 4,477,134	$ 210,780		$ 230,659	$ 19,879	$	34

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,477,134	$ 210,780		$ 230,659	$ 19,879	$	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)		$ 4,477,134	$ 210,780		$ 230,659	$ 19,879	$	34

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,477,134	$ 210,780		$ 230,659	$ 19,879	$	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)		$ 4,477,134	$ 210,780		$ 230,659	$ 19,879	$	34

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 Report Period Beginning: 1-01-10 Ending: 12-31-10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,131,676	$ 165,857	$ 165,857	$		$	71
72	Current Year Purchases	57,667						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,189,343	$ 165,857	$ 165,857	$		$	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		2008 Chevy Van		$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,766,477	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 376,637	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 396,516	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 19,879	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	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 12,578 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 Report Period Beginning: 1-01-10 Ending: 12-31-10

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		452		452
3	Classroom Wages (a)				
4	Clinical Wages (b)		17,272		17,272
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 17,724	$	$ 17,724
10	SUM OF line 9, col. 1 and 2 (e)	$ 17,724			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 Report Period Beginning: 1-01-10 Ending: 12-31-10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 394,140	$		$ 394,140	1
2	Licensed Speech and Language Development Therapist		hrs			99,797			99,797	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			422,679	48		422,727	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				533,976		533,976	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					63,122			63,122	13
14	TOTAL			$		$ 979,738	$ 534,024		$ 1,513,762	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.

STATE OF ILLINOIS

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 Report 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,548	$	1
2	Cash-Patient Deposits	11,263		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	320,636		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,077		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,258,702)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (909,178)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (909,178)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 229,968	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,263		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	587,175		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,426		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 831,832	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	117,350		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 117,350	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 949,182	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,858,360)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (909,178)	$	48

***(See instructions.)**

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 Report Period Beginning: 1-01-10 Ending: 12-31-10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,562,365)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,562,365)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(295,995)	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)**	$ (295,995)	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)**	$ (1,858,360)	24 *

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

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,861,036	1
2	Discounts and Allowances for all Levels	(2,980,407)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,880,629	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,665,135	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,665,135	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	42,037	12
13	Barber and Beauty Care	59,161	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	910,795	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	37,116	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,049,109	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,439	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,439	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other	(2,689)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (2,689)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,598,623	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,063,122	31
32	Health Care	5,657,851	32
33	General Administration	2,225,131	33
	B. Capital Expense		
34	Ownership	1,064,108	34
	C. Ancillary Expense		
35	Special Cost Centers	40,270	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Other	(155,864)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,894,618	40
41	**Income before Income Taxes (line 30 minus line 40)****	(295,995)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (295,995)	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 Barton W Stone-Jacksonville # 0048918 Report Period Beginning: 1-01-10 Ending: 12-31-10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,880	2,080	$ 66,822	$ 32.13	1
2	Assistant Director of Nursing	3,740	4,232	96,404	22.78	2
3	Registered Nurses	5,833	5,957	206,407	34.65	3
4	Licensed Practical Nurses	49,880	53,369	1,158,161	21.70	4
5	CNAs & Orderlies	145,552	153,967	2,052,637	13.33	5
6	CNA Trainees	400	400	17,272	43.18	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,256	3,458	73,474	21.25	8
9	Activity Director					9
10	Activity Assistants	10,988	11,746	134,018	11.41	10
11	Social Service Workers	3,732	4,193	76,388	18.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	43,071	46,702	520,293	11.14	15
16	Dishwashers					16
17	Maintenance Workers	9,603	10,208	140,927	13.81	17
18	Housekeepers	25,220	24,734	256,068	10.35	18
19	Laundry	9,382	10,281	125,521	12.21	19
20	Administrator	1,900	2,080	97,646	46.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,745	20,503	322,004	15.71	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)	333,182	353,910	$ 5,344,042 *	$ 15.10	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		5,400		36
37	Medical Records Consultant		3,465		37
38	Nurse Consultant				38
39	Pharmacist Consultant		12,540		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		5,255		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 26,660		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	62	$ 2,463		50
51	Licensed Practical Nurses	378	13,227		51
52	Certified Nurse Assistants/Aides	0	6,674		52
53	TOTAL (lines 50 - 52)	439	$ 22,364		53

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 Report Period Beginning: 1-01-10 Ending: 12-31-10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mike Schneider			$ 97,646
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,646

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Mgt Fee	$ 472,182
McQuellen Consulting	R/E appeals	4,931
Legal adj to Zero		33,438
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 510,551

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,891
Unemployment Compensation Insurance	41,557
FICA Taxes	408,819
Employee Health Insurance	392,867
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	0
Other Benefits	53,370
Central Office Allocation	66,456
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,035,960

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	9,594
Health Care Worker Background Check	
(Indicate # of checks performed)	2,910
Patient Background Checks	
	7,848
Dues & Subscriptions	15,945
License & Fees	870
Central Office Allocation	21,423
Less: Public Relations Expense	(7,848)
Non-allowable advertising	(1,698)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 49,044

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
	77
Seminar Expense	1,162
Central Office	760
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 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	Amount of Expense Amortized Per Year								
					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	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Barton W Stone-Jacksonville # 0048918 **Report Period Beginning:** 1-01-10 **Ending:** 12-31-10

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.
Barton Stone Home 46938 07/2007

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **101,288**
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. $ **13,260**

(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.