		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: 0048850

Facility Name: Heritage Manor-Carlinville

Address: 1200 University Avenue (Number) Carlinville (City) 62626 (Zip Code)

County: Macoupin

Telephone Number: (217) 854-4433 **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 Heritage Manor-Carlinville # 0048850 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	108	Skilled (SNF)	108	39,420	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	108	TOTALS	108	39,420	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	11,499	9,037	3,698	24,234	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,499	9,037	3,698	24,234	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.48%

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 3,698

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 Heritage Manor-Carlinville # 0048850 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	177,789	11,438		189,227		189,227	4,304	193,531			1
2	Food Purchase		147,869		147,869		147,869	(1,017)	146,852			2
3	Housekeeping	110,942	13,432		124,374		124,374		124,374			3
4	Laundry	34,588	11,633		46,221		46,221		46,221			4
5	Heat and Other Utilities			121,096	121,096		121,096	1,860	122,956			5
6	Maintenance	57,203	43,481	38,637	139,321		139,321	12,815	152,136			6
7	Other (specify):*											7
8	TOTAL General Services	380,522	227,853	159,733	768,108		768,108	17,962	786,070			8
	B. Health Care and Programs											
9	Medical Director			5,950	5,950		5,950	3,162	9,112			9
10	Nursing and Medical Records	1,216,019	88,475	12,165	1,316,659		1,316,659		1,316,659			10
10a	Therapy		276,122	456,018	732,140	(288,572)	443,568	180,962	624,530			10a
11	Activities	58,777	1,043		59,820		59,820	4	59,824			11
12	Social Services	28,850		3,043	31,893		31,893		31,893			12
13	CNA Training	3,543	2,128		5,671		5,671	1,427	7,098			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,307,189	367,768	477,176	2,152,133	(288,572)	1,863,561	185,555	2,049,116			16
	C. General Administration											
17	Administrative	58,336			58,336		58,336	91,428	149,764			17
18	Directors Fees											18
19	Professional Services			186,301	186,301		186,301	(167,634)	18,667			19
20	Dues, Fees, Subscriptions & Promotions			87,729	87,729	(59,130)	28,599	(5,084)	23,515			20
21	Clerical & General Office Expenses	154,909	25,744	9,622	190,275		190,275	187,153	377,428			21
22	Employee Benefits & Payroll Taxes			481,309	481,309		481,309	34,341	515,650			22
23	Inservice Training & Education			3,001	3,001		3,001	(1,002)	1,999			23
24	Travel and Seminar			750	750		750	1,249	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,862	48,862		48,862	12,285	61,147			26
27	Other (specify):*											27
28	TOTAL General Administration	213,245	25,744	817,574	1,056,563	(59,130)	997,433	152,736	1,150,169			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,900,956	621,365	1,454,483	3,976,804	(347,702)	3,629,102	356,253	3,985,355			29

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

Facility Name & ID Number Heritage Manor-Carlinville #0048850 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							196,044	196,044			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,858	7,858		7,858	34,116	41,974			32
33	Real Estate Taxes			4,353	4,353		4,353	41,338	45,691			33
34	Rent-Facility & Grounds			473,040	473,040		473,040	(465,886)	7,154			34
35	Rent-Equipment & Vehicles			4,280	4,280		4,280	1,312	5,592			35
36	Other (specify):*											36
37	TOTAL Ownership			489,531	489,531		489,531	(193,076)	296,455			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					288,572	288,572		288,572			39
40	Barber and Beauty Shops		296	7,772	8,068		8,068		8,068			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					59,130	59,130		59,130			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		296	7,772	8,068	347,702	355,770		355,770			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,900,956	621,661	1,951,786	4,474,403		4,474,403	163,177	4,637,580			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-Carlinville # 0048850 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	(5,159)	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)	(1,404)	23		16
17	Non-Care Related Fees	(1,113)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,377)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,774)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(15,041)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,868)		$	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)	198,045		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 198,045		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 163,177		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

Heritage Manor-Carlinville

ID# 0048850

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		(1,113)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(4,774)	19	22
23				23
24		0	27	24
25		(15,041)	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**	(20,928)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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	4,304	0	0	0	0	0	0	0	0	4,304	1
2	Food Purchase	0	0	(1,017)	0	0	0	0	0	0	0	0	(1,017)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,860	0	0	0	0	0	0	0	0	1,860	5
6	Maintenance	0	0	12,815	0	0	0	0	0	0	0	0	12,815	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	17,962	0	0	0	0	0	0	0	0	17,962	8
	B. Health Care and Programs													
9	Medical Director	0	0	3,162	0	0	0	0	0	0	0	0	3,162	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	180,962	0	0	0	0	0	0	0	0	0	180,962	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	1,427	0	0	0	0	0	0	0	0	1,427	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	180,962	4,593	0	0	0	0	0	0	0	0	185,555	16
	C. General Administration													
17	Administrative	0	0	91,428	0	0	0	0	0	0	0	0	91,428	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,774)	(181,527)	18,667	0	0	0	0	0	0	0	0	(167,634)	19
20	Fees, Subscriptions & Promotions	(16,154)	0	11,070	0	0	0	0	0	0	0	0	(5,084)	20
21	Clerical & General Office Expenses	0	0	187,153	0	0	0	0	0	0	0	0	187,153	21
22	Employee Benefits & Payroll Taxes	0	0	34,341	0	0	0	0	0	0	0	0	34,341	22
23	Inservice Training & Education	(1,404)	0	402	0	0	0	0	0	0	0	0	(1,002)	23
24	Travel and Seminar	(7,377)	0	8,626	0	0	0	0	0	0	0	0	1,249	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	12,285	0	0	0	0	0	0	0	0	12,285	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(29,709)	(181,527)	363,972	0	0	0	0	0	0	0	0	152,736	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,709)	(565)	386,527	0	0	0	0	0	0	0	0	356,253	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 **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	185,771	0	10,273	0	0	0	0	0	0	0	196,044	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,159)	38,623	0	652	0	0	0	0	0	0	0	34,116	32
33	Real Estate Taxes	0	41,279	0	59	0	0	0	0	0	0	0	41,338	33
34	Rent-Facility & Grounds	0	(473,040)	0	7,154	0	0	0	0	0	0	0	(465,886)	34
35	Rent-Equipment & Vehicles	0	0	0	1,312	0	0	0	0	0	0	0	1,312	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,159)	(207,367)	0	19,450	0	0	0	0	0	0	0	(193,076)	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)**	(34,868)	(207,932)	386,527	19,450	0	0	0	0	0	0	0	163,177	45

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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%	180,962	180,962	2
3	V								3
4	V	19	Adjustment for Related Organization	181,527	Heritage Operations Group, LLC	0.00%		(181,527)	4
5	V								5
6	V	34	Adjustment for Related Organization	473,040	Heritage Manor Real Estate, LLC	0.00%		(473,040)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		41,279	41,279	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		37,912	37,912	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		185,771	185,771	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		711	711	10
11	V								11
12	V								12
13	V								13
14	Total			$ 654,567			$ 446,635	$ * (207,932)	14

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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.		$	$ 4,304	15
16	V	2	Food Purchase					(1,017)	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,860	19
20	V	6	Maintenance					12,815	20
21	V	7	Other					0	21
22	V	9	Medical Director					3,162	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					1,427	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					91,428	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					18,667	31
32	V	20	Fees, Subscription, Promotions					11,070	32
33	V	21	Clerical & General Office Expenses					187,153	33
34	V	22	Employee Benefits & Payroll Taxes					34,341	34
35	V	23	Inservice Training & Education					402	35
36	V	24	Travel and Seminar					8,626	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					12,285	38
39	Total			$			$ 0	$ * 386,527	39

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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					10,273	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					652	18
19	V	33	Real Estate Taxes					59	19
20	V	34	Rent-Facility & Grounds					7,154	20
21	V	35	Rent-Equipment & Vehicles					1,312	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	$ * 19,450	39

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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-Carlinville # 0048850 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	108	$ 4,304	1
2	2	Food Purchase	Beds	2,634	25	(24,794)	0	108	(1,017)	2
3	3	Housekeeping	Beds	2,634	25	0	0	108	0	3
4	4	Laundry	Beds	2,634	25	0	0	108	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	45,364	0	108	1,860	5
6	6	Maintenance	Beds	2,634	25	312,555	75,007	108	12,815	6
7	7	Other	Beds	2,634	25	0	0	108	0	7
8	9	Medical Director	Beds	2,634	25	77,111	0	108	3,162	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	77,111	108	0	9
10	11	Activities	Beds	2,634	25	95	0	108	4	10
11	12	Social Service	Beds	2,634	25	0	0	108	0	11
12	13	Nurse Aide Training	Beds	2,634	25	34,804	0	108	1,427	12
13	14	Program Transportation	Beds	2,634	25	0	0	108	0	13
14	15	Other	Beds	2,634	25	0	0	108	0	14
15	17	Administrative	Beds	2,634	25	2,229,831	2,229,831	108	91,428	15
16	18	Directors Fees	Beds	2,634	25	0	0	108	0	16
17	19	Professional Services	Beds	2,634	25	455,276	0	108	18,667	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	269,994	0	108	11,070	18
19	21	Clerical & General Office Expens	Beds	2,634	25	4,564,447	4,163,572	108	187,153	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	837,533	0	108	34,341	20
21	23	Inservice Training & Education	Beds	2,634	25	9,793	0	108	402	21
22	24	Travel and Seminar	Beds	2,634	25	210,373	0	108	8,626	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	108	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	299,608	0	108	12,285	24
25	TOTALS					$ 9,426,959	$ 6,650,490		$ 386,527	25

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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	$	$	108	$	1
2	30	Depreciation	Beds	2,634	25	250,538		108	10,273	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25			108		3
4	32	Interest	Beds	2,634	25	15,900		108	652	4
5	33	Real Estate Taxes	Beds	2,634	25	1,448		108	59	5
6	34	Rent-Facility & Grounds	Beds	2,634	25	174,472		108	7,154	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	31,994		108	1,312	7
8	36	Other	Beds	2,634	25			108		8
9	38	Medically Nec Transportation	Beds	2,634	25			108		9
10	39	Ancillary Service Centers	Beds	2,634	25			108		10
11	40	Barber and Beauty Shops	Beds	2,634	25			108		11
12	41	Coffee and Gift Shops	Beds	2,634	25			108		12
13	42	Other	Beds	2,634	25			108		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	$		$ 19,450	25

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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			$	$ 827,549	3/2011	variable	$ 37,912	1
2	Bank of America		xx	Loan Fees							711	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							7,858	6
7												7
8												8
9	TOTAL Facility Related						$	$ 827,549			$ 46,481	9
	B. Non-Facility Related*											
10	Interest Income										(5,159)	10
11	Allocated Corporate										652	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,507)	14
15	TOTALS (line 9+line14)						$	$ 827,549			$ 41,974	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 Heritage Manor-Carlinville # 0048850 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.)		$ 41,279	2
3. Under or (over) accrual (line 2 minus line 1).		$ 41,279	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.		$ 41,279	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	38,496	8
	2006	40,216	9
	2007	42,289	10
	2008	41,701	11
	2009	41,279	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 Heritage Manor-Carlinville COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0048850

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.	1200026402	nursing home	$ 41,279.00	$ 41,279.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 41,279.00	$ 41,279.00

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 Heritage Manor-Carlinville # 0048850 Report Period Beginning: 1-01-10 Ending: 12-31-10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,527 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				$ 32,017	1
2					2
3	TOTALS			$ 32,017	3

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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	108				$ 3,265,145	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Heritage Manor Sign			1996	2,176						9
10	Architect Fees			1996	2,387						10
11	Laundry Room Electrical Repair			1996	3,019						11
12											12
13											13
14	Special Care Unit -- Remodel			1997	30,884						14
15											15
16	Remodel-- Alzheimer Wing			1998	78,813						16
17	A/C Unit			1998	950						17
18	Life Safety Improvements			1998	7,351						18
19	Shower Room Remodel			1998	2,811						19
20	Roof Replacement			1998	92,246						20
21											21
22	Door Alarm			1999	2,317						22
23	Smoke Damperer			1999	498						23
24	Water System			1999	8,115						24
25	Interior Painting--Material and Labor			1999	6,892						25
26	Shower Room Remodel			1999	2,453						26
27	Water Heater			1999	4,253						27
28											28
29											29
30											30
31											31
32											32
33	C/O Allocation							10,273	10,273		33
34	Book Depreciation					139,880		139,880			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-Carlinville # 0048850 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	Water Softener	2000	$ 3,802	$		$	$	$	37
38	Shower room Remodel ---Material and Labor	2000	3,608						38
39	A/C Rooftop Unit	2000	12,490						39
40	Pipe --Hallway Floor	2000	1,920						40
41									41
42	Electric Heater	2001	4,700						42
43									43
44	A/C Rooftop Unit-(remove)	2002	(12,490)						44
45	Heat / Cool Unit	2002	8,969						45
46	Floor Coverings	2002	6,638						46
47	Roof top unit	2002	4,995						47
48	Roof top unit	2002	2,918						48
49									49
50	Floor coverings	2003	10,318						50
51	Resurface parking lot	2003	25,786						51
52	A/C unit	2003	11,167						52
53	Dishwasher	2003	3,880						53
54	Boiler	2003	1,978						54
55	Backflow unit	2003	740						55
56	Heat / Cool Unit	2003	5,607						56
57									57
58	Hot Water Pump	2004	750						58
59	Heat / Cool Unit	2004	4,485						59
60	Booster Heater	2004	2,261						60
61	Door Closer	2004	578						61
62	A/C Unit	2004	1,101						62
63	Roof top unit	2004	3,504						63
64	Electric Heater	2004	13,454						64
65	Secure Care System	2004	3,053						65
66	Ansul System	2004	1,685						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,638,207	$ 139,880		$ 150,153	$ 10,273	$	70

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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		$ 3,638,207	$ 139,880		$ 150,153	$ 10,273	$	1
2	Window Replacement	2005	371						2
3	HVAC	2005	10,165						3
4	Rooftop A/C	2005	8,997						4
5	Water Storage Tank	2005	4,456						5
6	Rooftop Heater	2005	3,425						6
7									7
8	Sidewalk	2006	630						8
9	Parking Lot Sealer	2006	2,385						9
10	Window Replacement	2006	1,638						10
11	Resident room remodel -- paint, wall coverings	2006	3,390						11
12	Smoke detectors	2006	1,644						12
13									13
14	Resident room remodel -- paint, wall coverings	2007	4,207						14
15	Corridor Rehab -- Paint/Wallpaper	2007	22,058						15
16	HVAC	2007	9,819						16
17	Fire Alarm	2007	2,900						17
18	Rosedale Corridor Rehab-- Paint/ Wallpaper	2007	4,041						18
19	Sprinkler System	2007	3,398						19
20	Heat Detector	2007							20
21	Landscaping	2007							21
22	Rosedale Resident room Rehab -- Paint/Wallpaper	2007	26,384						22
23	Rooftop A/C	2007	4,417						23
24	Kitchen Repairs	2007	1,550						24
25	Asbestos Sample	2007							25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,754,082	$ 139,880		$ 150,153	$ 10,273	$	34

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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		$ 3,754,082	$ 139,880		$ 150,153	$ 10,273	$	1
2	PTAC Units	2008	7,980						2
3	Nurse call/Phone System	2008	157,428						3
4	Kitchen Water Heater	2008	2,600						4
5	Rosedale wing room remodel-- paint/flooring	2008	15,673						5
6	Kitchen plumbing	2008	3,130						6
7	Sprinkler	2008	5,972						7
8	Legacy Unit Remodel--paint/flooring	2008	37,068						8
9	Fire Alarm	2008	47,279						9
10									10
11	Sewer Line	2009	6,355						11
12	Therapy Renovation: paint, electrical, flooring	2009	76,398						12
13	Kitchen pipe	2009	2,700						13
14	Shower	2009	5,080						14
15	Door Alarms	2009	42,322						15
16	Nurse call/Phone System	2009	35,992						16
17	Fire Alarm	2009	15,451						17
18									18
19	Concrete Work & Install Curtins -- therapy room	2010	3,904						19
20	PTAC Units	2010	3,530						20
21	Flooring/Installation Shower room floor	2010	20,394						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)		$ 4,243,338	$ 139,880		$ 150,153	$ 10,273	$	34

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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		$ 4,243,338	$ 139,880		$ 150,153	$ 10,273	$	1
2									2
3									3
4									4
5									5
6									6
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,243,338	$ 139,880		$ 150,153	$ 10,273	$	34

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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	$ 689,513	$ 45,891	$ 45,891	$		$	71
72	Current Year Purchases	14,211						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 703,724	$ 45,891	$ 45,891	$		$	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	4,979,079	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	185,771	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	196,044	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	10,273	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 Heritage Manor-Carlinville # 0048850 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: $ 4,280 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 Heritage Manor-Carlinville # 0048850 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		2,128		2,128
3	Classroom Wages (a)				
4	Clinical Wages (b)		3,543		3,543
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 5,671	$	$ 5,671
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,671			

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 Heritage Manor-Carlinville # 0048850 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 181,944	$		$ 181,944	1
2	Licensed Speech and Language Development Therapist		hrs			67,604			67,604	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			193,358	662		194,020	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				275,460		275,460	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					13,112			13,112	13
14	TOTAL			$		$ 456,018	$ 276,122		$ 732,140	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-Carlinville # 0048850 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	$ 17,201	$	1
2	Cash-Patient Deposits	7,346		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	266,093		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,265		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,024,791)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,718,886)	$	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)**	$ (1,718,886)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 135,161	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,346		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	183,177		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,842		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)**	$ 344,526	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 344,526	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,063,412)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (1,718,886)	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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**	$ (2,025,562)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,025,562)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(37,850)	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)**	$ (37,850)	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)**	$ (2,063,412)	24 *

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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	$ 4,210,874	1
2	Discounts and Allowances for all Levels	(1,818,498)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,392,376	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,512,745	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,512,745	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	790	12
13	Barber and Beauty Care	11,198	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	497,219	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	17,066	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 526,273	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,159	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,159	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,436,553	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	768,108	31
32	Health Care	2,152,133	32
33	General Administration	1,056,563	33
	B. Capital Expense		
34	Ownership	489,531	34
	C. Ancillary Expense		
35	Special Cost Centers	8,068	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,474,403	40
41	**Income before Income Taxes (line 30 minus line 40)****	(37,850)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (37,850)	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-Carlinville # 0048850 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	1,520	1,544	$ 59,379	$ 38.46	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	2,596	2,882	101,145	35.10	3
4	Licensed Practical Nurses	17,176	18,874	328,115	17.38	4
5	CNAs & Orderlies	60,586	65,431	668,192	10.21	5
6	CNA Trainees	1,000	1,000	3,543	3.54	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,433	3,648	59,188	16.22	8
9	Activity Director					9
10	Activity Assistants	4,634	5,366	58,777	10.95	10
11	Social Service Workers	1,860	1,950	28,850	14.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,297	17,472	177,789	10.18	15
16	Dishwashers					16
17	Maintenance Workers	4,191	4,521	57,203	12.65	17
18	Housekeepers	9,808	10,214	110,942	10.86	18
19	Laundry	5,104	5,254	34,588	6.58	19
20	Administrator	1,900	2,080	58,336	28.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,056	9,806	154,909	15.80	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)	139,161	150,042	$ 1,900,956 *	$ 12.67	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		5,950		36
37	Medical Records Consultant		4,870		37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,480		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		3,043		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,343		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 Report Period Beginning: 1-01-10 Ending: 12-31-10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jason Jones			$ 58,336
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 58,336

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	$ 181,527
McQuellen Consulting	R/E appeals	0
Legal adj to Zero		4,774
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 186,301

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 111,406
Unemployment Compensation Insurance	16,152
FICA Taxes	145,423
Employee Health Insurance	200,902
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	0
Other Benefits	7,426
Central Office Allocation	34,341
TOTAL (agree to Schedule V, line 22, col.8)	$ 515,650

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	1,228
Health Care Worker Background Check (Indicate # of checks performed)	2,290
Patient Background Checks	
	8,702
Dues & Subscriptions	9,028
License & Fees	1,012
Central Office Allocation	11,070
Less: Public Relations Expense	(8,702)
Non-allowable advertising	(1,113)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,515

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
	160
Seminar Expense	590
Central Office	1,249
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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 Heritage Manor-Carlinville # 0048850 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.
Heritage Manor Carlinville 41509 07/2007

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **59,130**
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. $ **7,649**

(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.