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: 0048116

Facility Name: Heritage Manor-Gibson City

Address: 620 E. 1st Street (Number) Gibson City (City) 60936 (Zip Code)

County: Ford

Telephone Number: (217) 784-4257 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 07/2006

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-Gibson City # 0048116 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	75	Skilled (SNF)	75	27,375	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	75	TOTALS	75	27,375	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	15,842	4,265	1,449	21,556	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,842	4,265	1,449	21,556	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.74%

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 07/2006

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 1,449

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-Gibson City # 0048116 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	175,020	8,439		183,459		183,459	2,989	186,448			1
2	Food Purchase		124,380		124,380		124,380	(706)	123,674			2
3	Housekeeping	51,322	14,921		66,243		66,243		66,243			3
4	Laundry	37,908	5,749		43,657		43,657		43,657			4
5	Heat and Other Utilities			67,611	67,611		67,611	1,292	68,903			5
6	Maintenance	61,734	36,920	25,892	124,546		124,546	8,900	133,446			6
7	Other (specify):*											7
8	**TOTAL General Services**	325,984	190,409	93,503	609,896		609,896	12,475	622,371			8
	B. Health Care and Programs											
9	Medical Director			6,800	6,800		6,800	2,196	8,996			9
10	Nursing and Medical Records	1,001,109	82,622	23,409	1,107,140		1,107,140		1,107,140			10
10a	Therapy		130,622	170,666	301,288	(141,926)	159,362	168,286	327,648			10a
11	Activities	48,197	2,476		50,673		50,673	3	50,676			11
12	Social Services	31,672		2,914	34,586		34,586		34,586			12
13	CNA Training							991	991			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,080,978	215,720	203,789	1,500,487	(141,926)	1,358,561	171,476	1,530,037			16
	C. General Administration											
17	Administrative	62,634			62,634		62,634	63,492	126,126			17
18	Directors Fees											18
19	Professional Services			153,765	153,765		153,765	(139,302)	14,463			19
20	Dues, Fees, Subscriptions & Promotions			61,627	61,627	(41,063)	20,564	(2,724)	17,840			20
21	Clerical & General Office Expenses	119,039	23,006	7,364	149,409		149,409	129,967	279,376			21
22	Employee Benefits & Payroll Taxes			301,831	301,831		301,831	23,848	325,679			22
23	Inservice Training & Education			2,241	2,241		2,241	(242)	1,999			23
24	Travel and Seminar			170	170		170	1,829	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			41,994	41,994		41,994	8,531	50,525			26
27	Other (specify):*			1,000	1,000		1,000		1,000			27
28	**TOTAL General Administration**	181,673	23,006	569,992	774,671	(41,063)	733,608	85,399	819,007			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,588,635	429,135	867,284	2,885,054	(182,989)	2,702,065	269,350	2,971,415			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-Gibson City #0048116 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							104,104	104,104			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,460	5,460		5,460	50,384	55,844			32
33	Real Estate Taxes							41,069	41,069			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(323,532)	4,968			34
35	Rent-Equipment & Vehicles			23,422	23,422		23,422	911	24,333			35
36	Other (specify):*											36
37	TOTAL Ownership			357,382	357,382		357,382	(127,064)	230,318			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					141,926	141,926		141,926			39
40	Barber and Beauty Shops			3,386	3,386		3,386		3,386			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					41,063	41,063		41,063			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			3,386	3,386	182,989	186,375		186,375			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,588,635	429,135	1,228,052	3,245,822		3,245,822	142,286	3,388,108			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-Gibson City # 0048116 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	(4,335)	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)	(521)	23		16
17	Non-Care Related Fees	(803)	20		17
18	Fines and Penalties				18
19	Entertainment	(4,161)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,834)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(9,609)	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)	$ (27,263)		$	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)	169,549		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 169,549		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 142,286		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-Gibson City

ID# 0048116

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		(803)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(7,834)	19	22
23				23
24		0	27	24
25		(9,609)	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**	(18,246)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Gibson City **#** 0048116 **Report Period Beginning:** 1-01-10 **Ending:** 12-31-10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	2,989	0	0	0	0	0	0	0	0	2,989	1
2	Food Purchase	0	0	(706)	0	0	0	0	0	0	0	0	(706)	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	1,292	0	0	0	0	0	0	0	0	1,292	5
6	Maintenance	0	0	8,900	0	0	0	0	0	0	0	0	8,900	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	12,475	0	0	0	0	0	0	0	0	12,475	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,196	0	0	0	0	0	0	0	0	2,196	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	168,286	0	0	0	0	0	0	0	0	0	168,286	10a
11	Activities	0	0	3	0	0	0	0	0	0	0	0	3	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	991	0	0	0	0	0	0	0	0	991	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	168,286	3,190	0	0	0	0	0	0	0	0	171,476	16
	C. General Administration													
17	Administrative	0	0	63,492	0	0	0	0	0	0	0	0	63,492	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,834)	(144,431)	12,963	0	0	0	0	0	0	0	0	(139,302)	19
20	Fees, Subscriptions & Promotions	(10,412)	0	7,688	0	0	0	0	0	0	0	0	(2,724)	20
21	Clerical & General Office Expenses	0	0	129,967	0	0	0	0	0	0	0	0	129,967	21
22	Employee Benefits & Payroll Taxes	0	0	23,848	0	0	0	0	0	0	0	0	23,848	22
23	Inservice Training & Education	(521)	0	279	0	0	0	0	0	0	0	0	(242)	23
24	Travel and Seminar	(4,161)	0	5,990	0	0	0	0	0	0	0	0	1,829	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	8,531	0	0	0	0	0	0	0	0	8,531	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(22,928)	(144,431)	252,758	0	0	0	0	0	0	0	0	85,399	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,928)	23,855	268,423	0	0	0	0	0	0	0	0	269,350	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 **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	96,970	0	7,134	0	0	0	0	0	0	0	104,104	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,335)	54,266	0	453	0	0	0	0	0	0	0	50,384	32
33	Real Estate Taxes	0	41,028	0	41	0	0	0	0	0	0	0	41,069	33
34	Rent-Facility & Grounds	0	(328,500)	0	4,968	0	0	0	0	0	0	0	(323,532)	34
35	Rent-Equipment & Vehicles	0	0	0	911	0	0	0	0	0	0	0	911	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,335)	(136,236)	0	13,507	0	0	0	0	0	0	0	(127,064)	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)**	(27,263)	(112,381)	268,423	13,507	0	0	0	0	0	0	0	142,286	45

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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%	168,286	168,286	2
3	V								3
4	V	19	Adjustment for Related Organization	144,431	Heritage Operations Group, LLC	0.00%		(144,431)	4
5	V								5
6	V	34	Adjustment for Related Organization	328,500	Heritage Manor Real Estate, LLC	0.00%		(328,500)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		41,028	41,028	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		47,809	47,809	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		96,970	96,970	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		6,457	6,457	10
11	V								11
12	V								12
13	V								13
14	Total			$ 472,931			$ 360,550	$ * (112,381)	14

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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.		$	$ 2,989	15
16	V	2	Food Purchase					(706)	16
17	V	3	Housekeeping					0	17
18	V	4	Laundry					0	18
19	V	5	Heat & Other Utilities					1,292	19
20	V	6	Maintenance					8,900	20
21	V	7	Other					0	21
22	V	9	Medical Director					2,196	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					3	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					991	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					63,492	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					12,963	31
32	V	20	Fees, Subscription, Promotions					7,688	32
33	V	21	Clerical & General Office Expenses					129,967	33
34	V	22	Employee Benefits & Payroll Taxes					23,848	34
35	V	23	Inservice Training & Education					279	35
36	V	24	Travel and Seminar					5,990	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					8,531	38
39	Total			$			$ 0	$ * 268,423	39

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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					7,134	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					453	18
19	V	33	Real Estate Taxes					41	19
20	V	34	Rent-Facility & Grounds					4,968	20
21	V	35	Rent-Equipment & Vehicles					911	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	$ * 13,507	39

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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-Gibson City # 0048116 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	75	$ 2,989	1
2	2	Food Purchase	Beds	2,634	25	(24,794)	0	75	(706)	2
3	3	Housekeeping	Beds	2,634	25	0	0	75	0	3
4	4	Laundry	Beds	2,634	25	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	45,364	0	75	1,292	5
6	6	Maintenance	Beds	2,634	25	312,555	75,007	75	8,900	6
7	7	Other	Beds	2,634	25	0	0	75	0	7
8	9	Medical Director	Beds	2,634	25	77,111	0	75	2,196	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	77,111	75	0	9
10	11	Activities	Beds	2,634	25	95	0	75	3	10
11	12	Social Service	Beds	2,634	25	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,634	25	34,804	0	75	991	12
13	14	Program Transportation	Beds	2,634	25	0	0	75	0	13
14	15	Other	Beds	2,634	25	0	0	75	0	14
15	17	Administrative	Beds	2,634	25	2,229,831	2,229,831	75	63,492	15
16	18	Directors Fees	Beds	2,634	25	0	0	75	0	16
17	19	Professional Services	Beds	2,634	25	455,276	0	75	12,963	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	269,994	0	75	7,688	18
19	21	Clerical & General Office Expens	Beds	2,634	25	4,564,447	4,163,572	75	129,967	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	837,533	0	75	23,848	20
21	23	Inservice Training & Education	Beds	2,634	25	9,793	0	75	279	21
22	24	Travel and Seminar	Beds	2,634	25	210,373	0	75	5,990	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	299,608	0	75	8,531	24
25	TOTALS					$ 9,426,959	$ 6,650,490		$ 268,423	25

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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	$	$	75	$	1
2	30	Depreciation	Beds	2,634	25	250,538		75	7,134	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25			75		3
4	32	Interest	Beds	2,634	25	15,900		75	453	4
5	33	Real Estate Taxes	Beds	2,634	25	1,448		75	41	5
6	34	Rent-Facility & Grounds	Beds	2,634	25	174,472		75	4,968	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	31,994		75	911	7
8	36	Other	Beds	2,634	25			75		8
9	38	Medically Nec Transportation	Beds	2,634	25			75		9
10	39	Ancillary Service Centers	Beds	2,634	25			75		10
11	40	Barber and Beauty Shops	Beds	2,634	25			75		11
12	41	Coffee and Gift Shops	Beds	2,634	25			75		12
13	42	Other	Beds	2,634	25			75		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	$		$ 13,507	25

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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			$	$ 688,689	3/2011	variable	$ 47,809	1
2	Bank of America		xx	Loan Fees							6,457	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							5,460	6
7												7
8												8
9	TOTAL Facility Related						$	$ 688,689			$ 59,726	9
	B. Non-Facility Related*											
10	Interest Income										(4,335)	10
11	Allocated Corporate										453	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,882)	14
15	TOTALS (line 9+line14)						$	$ 688,689			$ 55,844	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-Gibson City # 0048116 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.)		$ 41,028	2
3. Under or (over) accrual (line 2 minus line 1).		$ 41,028	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.		$ 41,028	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	42,119	8
	2006	39,581	9
	2007	39,352	10
	2008	40,006	11
	2009	41,028	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-Gibson City COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0048116

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.	091111482001	nursing home	$ 40,880.00	$ 40,880.00
2.	091111479017		$ 148.00	$ 148.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 41,028.00	$ 41,028.00

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-Gibson City # 0048116 Report Period Beginning: 1-01-10 Ending: 12-31-10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,183 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				$ 20,000	1
2					2
3	TOTALS			$ 20,000	3

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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	75				$ 815,350	$		$	$	$	4
5					912,769						5
6											6
7											7
8											8
	Improvement Type**										
9	1981 Improvements			1981	41,753						9
10	1982 Improvements			1982	6,437						10
11	1983 Improvements			1983	240						11
12	1984 Improvements			1984	873						12
13	1985 Improvements			1985	7,530						13
14	1986 Improvements			1986	20,979						14
15	1987 Improvements			1987	2,222						15
16	1988 Improvements			1988	2,452						16
17	1989 Improvements			1989	28,639						17
18	1990 Improvements			1990	99,326						18
19	1991 Improvements			1991	36,637						19
20	1993 Improvements			1993	40,838						20
21	1994 Improvements			1994	66,399						21
22	1995 Improvements			1995	1,060						22
23	WINDOW REPLACEMENTS			1996	25,247						23
24	WATER HEATER			1996	1,639						24
25	RESIDENT ROOM REMODEL/PAINTING			1996	7,584						25
26	Parking Lot			1998	12,299						26
27											27
28	Smoke Dampers			1999	5,256						28
29	Water Heater			1999	1,971						29
30	Garbage Disposal			1999	1,693						30
31	Heat/Cool compressor			1999	3,277						31
32	Smoke Dampers			2000	1,295						32
33	C/O Allocation							7,134	7,134		33
34	Book Depreciation					73,615		73,615			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-Gibson City # 0048116 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	Temperature Control Unit	2001	$ 1,700	$		$	$	$	37
38	AC Replacement	2001	4,400						38
39	Smoke Detection System								39
40									40
41	Smoke Detection System	2002	1,775						41
42	Landscaping	2002	1,425						42
43	Fire Supression	2002	4,458						43
44	Water Heater	2002	2,396						44
45	Keypad Perimeter	2002	941						45
46	Sealcoat Parking Lot	2002	1,371						46
47	Garbage Disposal	2002	1,520						47
48	Hot Water Tank	2002	3,168						48
49	Rehab Hallway--Wallpaper/Paint	2002	14,442						49
50									50
51	Exterior Doors	2003	2,195						51
52	Roof Replacement	2003	28,555						52
53	Security Door	2003	1,116						53
54	Water Heater	2003	1,999						54
55	Water Tank	2003	1,836						55
56									56
57	HVAC unit	2004	5,247						57
58	Grease Trap	2004	1,903						58
59	Quarry Tile	2004	3,165						59
60	Parking Lot Sealcoat	2004	1,579						60
61	HVAC unit	2004	1,000						61
62	Sprinkler Leak	2004	1,854						62
63	Hot Water Boiler	2004	2,133						63
64	Corridor Remodel Material and Labor	2004	20,242						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,254,185	$ 73,615		$ 80,749	$ 7,134	$	70

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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		$ 2,254,185	$ 73,615		$ 80,749	$ 7,134	$	1
2	Oxygen Room	2005	2,005						2
3	Heat/Cool Unit	2005	17,228						3
4									4
5	Heat/Cool Units	2006	25,182						5
6	Door	2006	2,887						6
7	Heater	2006	1,078						7
8	Sidewalk	2006	3,500						8
9	Boiler	2006	1,427						9
10	Remodel TLC Unit --carpet, paint,	2006	27,516						10
11	Parking Lot sealer	2006	1,699						11
12	Drapes	2006	1,172						12
13	adjustments	2006	(7,711)						13
14	dishwasher motor	2007							14
15	Remodel TLC Unit --carpet, paint,	2007	2,996						15
16	Water Heater	2007	2,907						16
17	Grease Trap	2007							17
18	Water Softener	2007	12,285						18
19									19
20	Emergency Alarms	2008	36,893						20
21									21
22	Water Heater	2008	4,982						22
23	Exterior Painting	2008	9,720						23
24									24
25	Sprinkler System	2009	11,980						25
26	Water Heater	2009	4,503						26
27	Generator	2009	26,450						27
28									28
29	Water Heater	2010	3,750						29
30	Generator	2010	43,596						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,490,230	$ 73,615		$ 80,749	$ 7,134	$	34

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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		$ 2,490,230	$ 73,615		$ 80,749	$ 7,134	$	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
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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)		$ 2,490,230	$ 73,615		$ 80,749	$ 7,134	$	34

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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		$ 2,490,230	$ 73,615		$ 80,749	$ 7,134	$	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
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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)		$ 2,490,230	$ 73,615		$ 80,749	$ 7,134	$	34

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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	$ 455,979	$ 23,355	$ 23,355	$		$	71
72	Current Year Purchases	7,992						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 463,971	$ 23,355	$ 23,355	$		$	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)	$	2,974,201	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	96,970	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	104,104	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	7,134	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-Gibson City # 0048116 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: $ 23,422 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-Gibson City # 0048116 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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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	$		$ 76,158	$		$ 76,158	1
2	Licensed Speech and Language Development Therapist		hrs			11,988			11,988	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			70,675	541		71,216	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				130,081		130,081	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					11,845			11,845	13
14	TOTAL			$		$ 170,666	$ 130,622		$ 301,288	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-Gibson City # 0048116 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	$ 22,484	$	1
2	Cash-Patient Deposits	9,643		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	105,245		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,828		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,051,425)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (900,225)	$	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)**	$ (900,225)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 102,727	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,643		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,785		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,211		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)**	$ 254,366	$	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)**	$ 254,366	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,154,591)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (900,225)	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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**	$ (1,079,699)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,079,699)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(74,892)	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)**	$ (74,892)	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)**	$ (1,154,591)	24 *

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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	$ 3,209,947	1
2	Discounts and Allowances for all Levels	(780,736)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,429,211	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	522,107	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 522,107	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	1,464	12
13	Barber and Beauty Care	5,410	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	208,384	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	19	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 215,277	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,335	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,335	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)**	$ 3,170,930	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	609,896	31
32	Health Care	1,500,487	32
33	General Administration	774,671	33
	B. Capital Expense		
34	Ownership	357,382	34
	C. Ancillary Expense		
35	Special Cost Centers	3,386	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)***	$ 3,245,822	40
41	**Income before Income Taxes (line 30 minus line 40)****	(74,892)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (74,892)	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-Gibson City # 0048116 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	2,000	2,160	$ 58,734	$ 27.19	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,212	4,543	243,051	53.50	3
4	Licensed Practical Nurses	10,146	10,535	201,614	19.14	4
5	CNAs & Orderlies	36,645	38,820	478,512	12.33	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,053	3,839	19,198	5.00	8
9	Activity Director					9
10	Activity Assistants	4,042	4,212	48,197	11.44	10
11	Social Service Workers	1,937	2,191	31,672	14.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,736	17,830	175,020	9.82	15
16	Dishwashers					16
17	Maintenance Workers	5,061	5,452	61,734	11.32	17
18	Housekeepers	6,231	6,777	51,322	7.57	18
19	Laundry	1,828	2,018	37,908	18.78	19
20	Administrator	1,900	2,080	62,634	30.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,218	7,383	119,039	16.12	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)	99,009	107,840	$ 1,588,635 *	$ 14.73	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		6,800		36
37	Medical Records Consultant		1,840		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,500		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,914		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 16,054		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	139	$ 5,576		50
51	Licensed Practical Nurses	287	10,051		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)	427	$ 15,627		53

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 Report Period Beginning: 1-01-10 Ending: 12-31-10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Christensen			$ 62,634
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 62,634

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	$ 144,431
McQuellen Consulting	R/E appeals	1,500
Legal adj to Zero		7,834
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 153,765

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,483
Unemployment Compensation Insurance	13,828
FICA Taxes	121,531
Employee Health Insurance	130,900
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	0
Other Benefits	15,089
Central Office Allocation	23,848
TOTAL (agree to Schedule V, line 22, col.8)	$ 325,679

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	3,390
Health Care Worker Background Check (Indicate # of checks performed ____)	1,480
Patient Background Checks	
	5,023
Dues & Subscriptions	5,086
License & Fees	999
Central Office Allocation	7,688
Less: Public Relations Expense	(5,023)
Non-allowable advertising	(803)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,840

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
	60
Seminar Expense	110
Central Office	1,829
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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-Gibson City # 0048116 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 Gibson City 38315 07/2006

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **41,063**
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. $ **9,422**

(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.