

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 48132

Facility Name: Heritage Manor Elgin, LLC.

Address: Raymond & Watch Elgin 60120
Number City Zip Code

County: Kane

Telephone Number: (847) 697-6636 Fax # ()

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

x

 PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

x

 Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

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 01/01/11 to 12/31/11
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)
(Type or Print Name) Craig Ater
(Title) Exec VP & CFO

Paid
Preparer

(Signed)
(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 Elgin, LLC.

48132 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>94</u>	Skilled (SNF)	<u>94</u>	<u>34,310</u>	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	<u>94</u>	TOTALS	<u>94</u>	<u>34,310</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,560</u>	<u>2,816</u>	<u>4,403</u>	<u>28,779</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,560</u>	<u>2,816</u>	<u>4,403</u>	<u>28,779</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.88%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

none

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started July 2006

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date July 2006 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified _____ and days of care provided 4,403

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Manor Elgin, LLC. # 48132 Report Period Beginning: 01/01/11 Ending: 12/31/11
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	248,279	6,909		255,188		255,188	5,274	260,462			1
2	Food Purchase		218,220		218,220		218,220	18	218,238			2
3	Housekeeping	97,570	35,867		133,437		133,437	7	133,444			3
4	Laundry	56,113	23,400		79,513		79,513	5	79,518			4
5	Heat and Other Utilities			121,258	121,258		121,258	1,858	123,116			5
6	Maintenance	85,174	48,572	51,070	184,816		184,816	13,671	198,487			6
7	Other (specify):*											7
8	TOTAL General Services	487,136	332,968	172,328	992,432		992,432	20,833	1,013,265			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	76	12,076			9
10	Nursing and Medical Records	1,828,937	115,938	24,030	1,968,905		1,968,905		1,968,905			10
10a	Therapy		313,364	611,311	924,675	(317,680)	606,995	118,848	725,843			10a
11	Activities	67,923	8,407		76,330		76,330		76,330			11
12	Social Services	28,515		3,899	32,414		32,414		32,414			12
13	CNA Training	1,086	1,205		2,291		2,291	756	3,047			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,926,461	438,914	651,240	3,016,615	(317,680)	2,698,935	119,680	2,818,615			16
	C. General Administration											
17	Administrative	100,042			100,042		100,042	80,253	180,295			17
18	Directors Fees											18
19	Professional Services			252,760	252,760		252,760	(243,167)	9,593			19
20	Dues, Fees, Subscriptions & Promotions			95,131	95,131	(51,465)	43,666	(28,618)	15,048			20
21	Clerical & General Office Expenses	211,939	41,979	13,961	267,879		267,879	177,070	444,949			21
22	Employee Benefits & Payroll Taxes			471,306	471,306		471,306	37,231	508,537			22
23	Inservice Training & Education			659	659		659	463	1,122			23
24	Travel and Seminar			7,498	7,498		7,498	(5,499)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			60,564	60,564		60,564	10,911	71,475			26
27	Other (specify):*			51,449	51,449		51,449	(51,420)	29			27
28	TOTAL General Administration	311,981	41,979	953,328	1,307,288	(51,465)	1,255,823	(22,776)	1,233,047			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,725,578	813,861	1,776,896	5,316,335	(369,145)	4,947,190	117,737	5,064,927			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							125,147	125,147			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,153	9,153		9,153	32,491	41,644			32
33	Real Estate Taxes							47,886	47,886			33
34	Rent-Facility & Grounds			411,720	411,720		411,720	(410,824)	896			34
35	Rent-Equipment & Vehicles			2,734	2,734		2,734	875	3,609			35
36	Other (specify):*											36
37	TOTAL Ownership			423,607	423,607		423,607	(204,425)	219,182			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					317,680	317,680		317,680			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					51,465	51,465		51,465			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					369,145	369,145		369,145			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,725,578	813,861	2,200,503	5,739,942		5,739,942	(86,688)	5,653,254			45

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

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

	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	(7,432)	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)		23		16
17	Non-Care Related Fees	(1,121)	20		17
18	Fines and Penalties				18
19	Entertainment	(14,419)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	4,109	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(51,420)	27		24
25	Fund Raising, Advertising and Promotional	(32,696)	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)	\$ (102,979)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	16,291		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 16,291		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (86,688)		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

ID#48132

Report Period Beginning:01/01/11

Ending:12/31/11

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		(1,121)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		4,109	19	22
23				23
24		(51,420)	27	24
25		(32,696)	20	25
26				26
27				27
28				28
29			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	(81,128)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Elgin, LLC. # 48132 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	5,274	0	0	0	0	0	0	0	0	5,274	1
2	Food Purchase	0	0	18	0	0	0	0	0	0	0	0	18	2
3	Housekeeping	0	0	7	0	0	0	0	0	0	0	0	7	3
4	Laundry	0	0	5	0	0	0	0	0	0	0	0	5	4
5	Heat and Other Utilities	0	0	1,858	0	0	0	0	0	0	0	0	1,858	5
6	Maintenance	0	0	13,671	0	0	0	0	0	0	0	0	13,671	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	20,833	0	0	0	0	0	0	0	0	20,833	8
	B. Health Care and Programs													
9	Medical Director	0	0	76	0	0	0	0	0	0	0	0	76	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	118,848	0	0	0	0	0	0	0	0	0	118,848	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	756	0	0	0	0	0	0	0	0	756	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	118,848	832	0	0	0	0	0	0	0	0	119,680	16
	C. General Administration													
17	Administrative	0	0	80,253	0	0	0	0	0	0	0	0	80,253	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	4,109	(256,869)	9,593	0	0	0	0	0	0	0	0	(243,167)	19
20	Fees, Subscriptions & Promotions	(33,817)	0	5,199	0	0	0	0	0	0	0	0	(28,618)	20
21	Clerical & General Office Expenses	0	0	177,070	0	0	0	0	0	0	0	0	177,070	21
22	Employee Benefits & Payroll Taxes	0	0	37,231	0	0	0	0	0	0	0	0	37,231	22
23	Inservice Training & Education	0	0	463	0	0	0	0	0	0	0	0	463	23
24	Travel and Seminar	(14,419)	0	8,920	0	0	0	0	0	0	0	0	(5,499)	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	10,911	0	0	0	0	0	0	0	0	10,911	26
27	Other (specify):*	(51,420)	0	0	0	0	0	0	0	0	0	0	(51,420)	27
28	TOTAL General Administration	(95,547)	(256,869)	329,640	0	0	0	0	0	0	0	0	(22,776)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(95,547)	(138,021)	351,305	0	0	0	0	0	0	0	0	117,737	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Elgin, LLC. # 48132 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	114,071	0	11,076	0	0	0	0	0	0	0	125,147	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,432)	39,355	0	568	0	0	0	0	0	0	0	32,491	32
33	Real Estate Taxes	0	47,886	0	0	0	0	0	0	0	0	0	47,886	33
34	Rent-Facility & Grounds	0	(411,720)	0	896	0	0	0	0	0	0	0	(410,824)	34
35	Rent-Equipment & Vehicles	0	0	0	875	0	0	0	0	0	0	0	875	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(7,432)	(210,408)	0	13,415	0	0	0	0	0	0	0	(204,425)	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)	(102,979)	(348,429)	351,305	13,415	0	0	0	0	0	0	0	(86,688)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 Page 25				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$		1
2	V	10a	Adjustment for Related Organization		GreenTree Pharmacy	0.00%	118,848	118,848	2
3	V								3
4	V	19	Adjustment for Related Organization	256,869	Heritage Operations Group, LLC	0.00%		(256,869)	4
5	V								5
6	V	34	Adjustment for Related Organization	411,720	Heritage Manor Real Estate, LLC	0.00%		(411,720)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		47,886	47,886	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		33,796	33,796	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		114,071	114,071	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,559	5,559	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 668,589			\$ 320,160	\$ * (348,429)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.		\$	5,274	15
16	V	2	Food Purchase					18	16
17	V	3	Housekeeping					7	17
18	V	4	Laundry					5	18
19	V	5	Heat & Other Utilities					1,858	19
20	V	6	Maintenance					13,671	20
21	V	7	Other					0	21
22	V	9	Medical Director					76	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					756	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					80,253	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					9,593	31
32	V	20	Fees, Subscription, Promotions					5,199	32
33	V	21	Clerical & General Office Expenses					177,070	33
34	V	22	Employee Benefits & Payroll Taxes					37,231	34
35	V	23	Inservice Training & Education					463	35
36	V	24	Travel and Seminar					8,920	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					10,911	38
39	Total			\$			\$	0	\$ * 351,305 39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Enterprises, Inc.		\$	0	15
16	V	30	Depreciation					11,076	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					568	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					896	20
21	V	35	Rent-Equipment & Vehicles					875	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	\$ * 13,415 39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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		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 Elgin, LLC. # 48132 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,735	26	\$ 153,442	\$ 153,115	94	\$ 5,274	1
2	2	Food Purchase	Beds	2,735	26	520	0	94	18	2
3	3	Housekeeping	Beds	2,735	26	215	0	94	7	3
4	4	Laundry	Beds	2,735	26	151	0	94	5	4
5	5	Heat & Other Utilities	Beds	2,735	26	54,054	0	94	1,858	5
6	6	Maintenance	Beds	2,735	26	397,756	75,127	94	13,671	6
7	7	Other	Beds	2,735	26	0	0	94	0	7
8	9	Medical Director	Beds	2,735	26	2,206	0	94	76	8
9	10	Nursing & Medical Records	Beds	2,735	26	0	0	94	0	9
10	11	Activities	Beds	2,735	26	0	0	94	0	10
11	12	Social Service	Beds	2,735	26	0	0	94	0	11
12	13	Nurse Aide Training	Beds	2,735	26	22,009	20,793	94	756	12
13	14	Program Transportation	Beds	2,735	26	0	0	94	0	13
14	15	Other	Beds	2,735	26	0	0	94	0	14
15	17	Administrative	Beds	2,735	26	2,335,023	2,335,023	94	80,253	15
16	18	Directors Fees	Beds	2,735	26	0	0	94	0	16
17	19	Professional Services	Beds	2,735	26	279,109	0	94	9,593	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	151,258	0	94	5,199	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	5,151,979	4,517,846	94	177,070	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,083,278	0	94	37,231	20
21	23	Inservice Training & Education	Beds	2,735	26	13,460	0	94	463	21
22	24	Travel and Seminar	Beds	2,735	26	259,533	0	94	8,920	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	94	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	317,454	0	94	10,911	24
25	TOTALS					\$ 10,221,447	\$ 7,101,904		\$ 351,305	25

Facility Name & ID Number Heritage Manor Elgin, LLC. # 48132 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,735	26	\$		94	\$	1
2	30	Depreciation	Beds	2,735	26	322,258		94	11,076	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			94		3
4	32	Interest	Beds	2,735	26	16,517		94	568	4
5	33	Real Estate Taxes	Beds	2,735	26			94		5
6	34	Rent-Facility & Grounds	Beds	2,735	26	26,080		94	896	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	25,461		94	875	7
8	36	Other	Beds	2,735	26			94		8
9	38	Medically Nec Transportation	Beds	2,735	26			94		9
10	39	Ancillary Service Centers	Beds	2,735	26			94		10
11	40	Barber and Beauty Shops	Beds	2,735	26			94		11
12	41	Coffee and Gift Shops	Beds	2,735	26			94		12
13	42	Other	Beds	2,735	26			94		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					\$ 390,316	\$		\$ 13,415	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE											
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)											
	1	2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
	A. Directly Facility Related										
	Long-Term										
1	Bank of America		xx	Mortgage			\$	634,468	03/2016	variable	\$ 33,796 1
2	Bank of America		xx	Loan Fees							5,559 2
3											3
4											4
5											5
	Working Capital										
6	Bank of America		xx	Accounts Receivable							9,153 6
7											7
8											8
9	TOTAL Facility Related						\$	634,468			\$ 48,508 9
	B. Non-Facility Related*										
10	Interest Income										(7,432) 10
11	Allocated Corporate										568 11
12											12
13											13
14	TOTAL Non-Facility Related						\$				\$ (6,864) 14
15	TOTALS (line 9+line14)						\$	634,468			\$ 41,644 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.)

HFS 3745 (N-4-99)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 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.)			\$	47,886	2
3. Under or (over) accrual (line 2 minus line 1).			\$	47,886	3
4. Real Estate Tax accrual used for 2011 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.			\$	47,886	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	53,167	8	
		2007	59,527	9	
		2008	49,733	10	
		2009	50,366	11	
		2010	47,886	12	
				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor Elgin, LLC. COUNTY Kane

FACILITY IDPH LICENSE NUMBER 48132

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 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>0624201003</u>	<u>nursing home</u>	\$ <u>45,233.00</u>	\$ <u>45,233.00</u>
2.	<u>0624201004</u>	<u> </u>	\$ <u>1,144.00</u>	\$ <u>1,144.00</u>
3.	<u>0624201002</u>	<u> </u>	\$ <u>1,509.00</u>	\$ <u>1,509.00</u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>47,886.00</u></u>	\$ <u><u>47,886.00</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,804

B. General Construction Type: Exterior brickFrame wood

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 80,000	1
2					2
3	TOTALS			\$ 80,000	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	94				\$ 720,000	\$		\$		\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1989 Improvements			1989	180,739						9
10	1990 Improvements			1990	658,346						10
11	1990 Improvements			1990	4,320						11
12	1991 Improvements			1991	52,989						12
13	1992 Improvements			1992	6,777						13
14	1993 Improvements			1993	54,564						14
15	1994 Improvements			1994	81,347						15
16	1995 Improvements			1995	146,394						16
17	Remodel Resident Day Room/Nurses Station			1996	23,749						17
18	Interior Rehab			1997	751						18
19	Electric Water Heater			1997	3,965						19
20	Booster Heater			1997	1,622						20
21	Water Heater and Storage Tank			1998	6,485						21
22											22
23	Water Heater			1999	4,750						23
24	Code Alert System			1999	1,570						24
25	Resident Room Remodel--Material and Labor			1999	2,571						25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	C/O Allocation							11,076	11,076		33
34	Book Depreciation					85,826		85,826			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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 South Wing Remodel -- Labor / Materials	2000	\$ 14,334	\$		\$	\$	\$	37
38 Door	2000	1,535						38
39 Dry Chemical Extinguisher	2000	1,746						39
40								40
41 Water Heater	2001	4,935						41
42 Valve thermometer	2001	4,520						42
43 A/C Unit	2001	3,319						43
44 Hallway Carpet and Tile Material and Labor	2001	28,843						44
45 Wallpaper	2001	2,390						45
46 Nurse Call System	2001	21,612						46
47								47
48 Hallway and Room Carpet and Tile Material	2002	74,533						48
49 Labor	2002	68,734						49
50 Professional Fees	2002	16,497						50
51 Kitchen Pipe	2002	1,830						51
52 Shower Repairs	2002	5,063						52
53 A/C Unit	2002	5,864						53
54 Bathroom Rehab	2002	750						54
55 Condensor	2002	1,600						55
56 Hallway and Room Carpet and Tile Material --South wing	2002	5,777						56
57								57
58 Hallway and Room Carpet and Tile Material --South wing	2003	92,993						58
59 Exterior Door	2003	320						59
60 Parking Lot Sealer	2003	4,469						60
61 Door Security	2003	2,160						61
62 Ductwork	2003	6,628						62
63 compressor	2003	1,195						63
64 Blower Unit	2003	1,784						64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,324,370	\$ 85,826		\$ 96,902	\$ 11,076	\$	70

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 2,324,370	\$ 85,826		\$ 96,902	\$ 11,076		1
2									2
3	Exhaust fan	2005	1,950						3
4	Exterior Doors	2005	2,218						4
5	Compressor	2005	1,608						5
6									6
7	Fire Alarm	2006	1,714						7
8	Parking Lot	2006	2,344						8
9	Remodel Corridor --paint	2006	4,028						9
10	Water Main	2006	3,250						10
11									11
12	Roof	2007	94,451						12
13	Central Corridor paint, tile	2007	49,685						13
14	Plumbing fixtures	2007	2,400						14
15	Rooftop heat/cool unit	2007	5,565						15
16									16
17	A/C Units	2008	19,600						17
18	4 Ton A/C Unit	2008	2,600						18
19	HVAC Rooftop Unit	2008	11,000						19
20									20
21	Patio	2009	11,693						21
22	Front Entry Doors	2009	13,529						22
23	Front Office Carpet and Window Treatments	2009	3,864						23
24									24
25	Cat5 cable/wire facility	2010	6,607						25
26									26
27	Electric water heater	2011	11,750						27
28	Sign	2011	2,500						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,576,726	\$ 85,826		\$ 96,902	\$ 11,076		34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$2,576,726	\$85,826		\$96,902	\$11,076		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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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)		\$2,576,726	\$85,826		\$96,902	\$11,076		34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$2,576,726	\$85,826		\$96,902	\$11,076	\$	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
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,576,726	\$85,826		\$96,902	\$11,076	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$755,076	\$28,245	\$28,245	\$		\$	71
72	Current Year Purchases	13,856						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$768,932	\$28,245	\$28,245	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,425,658	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$114,071	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$125,147	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$11,076	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.

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:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$2,734
- 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

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. /2012 \$

13. /2013 \$

14. /2014 \$

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

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

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

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

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		1,205		1,205
3	Classroom Wages (a)				
4	Clinical Wages (b)		1,086		1,086
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,291	\$	\$ 2,291
10	SUM OF line 9, col. 1 and 2 (e)	\$ 2,291			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	\$		\$ 290,520	\$		\$ 290,520	1
2	Licensed Speech and Language Development Therapist		hrs			47,074			47,074	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			265,249	4,152		269,401	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				309,212		309,212	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					8,468			8,468	13
14	TOTAL			\$		\$ 611,311	\$ 313,364		\$ 924,675	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 800	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,167,095		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,291		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(534,577)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 657,609	\$	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)	\$ 657,609	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 227,994	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	278,527		30
31	Accrued Taxes Payable (excluding real estate taxes)	273		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)	\$ 506,794	\$	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)	\$ 506,794	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 150,815	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 657,609	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (161,682)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (161,682)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	312,497	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)	\$ 312,497	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)	\$ 150,815	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,786,456	1
2	Discounts and Allowances for all Levels	(2,144,420)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,642,036	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,852,394	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,852,394	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	550,577	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 550,577	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,432	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,432	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,052,439	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	992,432	31
32	Health Care	3,016,615	32
33	General Administration	1,307,288	33
	B. Capital Expense		
34	Ownership	423,607	34
	C. Ancillary Expense		
35	Special Cost Centers		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)*	\$ 5,739,942	40
41	Income before Income Taxes (line 30 minus line 40)**	312,497	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 312,497	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,952	2,016	\$ 82,951	\$ 41.15	1
2	Assistant Director of Nursing	1,936	2,260	72,802	32.21	2
3	Registered Nurses	13,607	13,906	479,518	34.48	3
4	Licensed Practical Nurses	7,374	7,849	209,810	26.73	4
5	CNAs & Orderlies	51,552	53,868	867,332	16.10	5
6	CNA Trainees	100	100	1,086	10.86	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,449	4,504	116,524	25.87	8
9	Activity Director					9
10	Activity Assistants	5,881	6,042	67,923	11.24	10
11	Social Service Workers	2,016	2,056	28,515	13.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,866	20,628	248,279	12.04	15
16	Dishwashers					16
17	Maintenance Workers	4,154	4,202	85,174	20.27	17
18	Housekeepers	9,298	9,491	97,570	10.28	18
19	Laundry	4,726	4,878	56,113	11.50	19
20	Administrator	1,900	2,080	100,042	48.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,084	9,593	211,939	22.09	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)	137,895	143,473	\$ 2,725,578 *	\$ 19.00	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		1,163		37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,640		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		3,899		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,702		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries					
Name	Function	Ownership %	Amount		
Linda Hartman			\$ 100,042		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,042		
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		\$ 256,869		
			0		
			0		
Legal adj to Zero			(4,109)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 252,760		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$ 57,271		
Unemployment Compensation Insurance			25,835		
FICA Taxes			208,507		
Employee Health Insurance			171,863		
Employee Meals					
Illinois Municipal Retirement Fund (IMRF)*					
			0		
Other Benefits			7,830		
Central Office Allocation			37,231		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 508,537		
E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Description		Line #	Amount		
			\$		
TOTAL			\$		
F. Dues, Fees, Subscriptions and Promotions					
Description			Amount		
IDPH License Fee			\$ 0		
Advertising: Employee Recruitment			2,119		
Health Care Worker Background Check (Indicate # of checks performed)			1,293		
Patient Background Checks					
			20,063		
Dues & Subscriptions			6,435		
License & Fees			1,123		
Central Office Allocation			5,199		
Less: Public Relations Expense			(20,063)		
Non-allowable advertising			(1,121)		
Yellow page advertising (			(		
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 15,048		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
			5,164		
			36		
Seminar Expense			2,298		
Central Office			(5,499)		
Entertainment Expense (			(		
(agree to Sch. V, line 24, col. 8)					
TOTAL			\$ 1,999		

*** Attach copy of IMRF notifications**

****See instructions.**

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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? 7 years
- (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 x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES xx 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 Elgin 38307 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 51,465
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 0
- (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

FACILITY		STATE
Owned SNFs		LICENSE NUMBER
Heritage Health - South, LLC		48843
Heritage Health - Bloomington, LLC		48157
Heritage Health - Carlinville, LLC		48850
Heritage Health - Chillicothe, LLC		48868
Heritage Health - Dwight, LLC		50492
Heritage Health - Elgin, LLC		48132
Heritage Health - El Paso, LLC		48124
Heritage Health - Gibson City, LLC		48116
Heritage Health - Gillespie, LLC		48892
Heritage Health - LaSalle, LLC		51276
Heritage Health - Litchfield, LLC		48900
Heritage Health - Mendota, LLC		48108
Heritage Health - Minonk, LLC		48058
Heritage Health - Mt. Sterling, LLC		48041
Heritage Health - Mt. Zion, LLC		48074
Heritage Health - Normal, LLC		48082
Heritage Health - Pana, LLC		48884
Heritage Health - Peru, LLC		48090
Heritage Health - Staunton, LLC		48876
Heritage Health - Streator, LLC		48066
Barton W. Stone Jacksonville, LLC		48918
Danville Joint Ventures, LLC d/b/aColonial Manor		42168
Heritage Health - Springfield		41699
Cotillion Ridge		45138
Country Health		7880
Mason City Area NH		34256
St. Clara's Manor		50724
Vonderlieth Living Center		19976