

		FOR BHF USE					

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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: 48116

Facility Name: Heritage Manor Gibson City, LLC.

Address: 525 Hazel Drive Gibson City 60936
Number City Zip Code

County: Ford

Telephone Number: (217) 784-4257 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 Gibson City, LLC.

48116 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	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	14,607	4,994	1,946	21,547	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,607	4,994	1,946	21,547	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.71%

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 1,946

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 Gibson City, LLC. # 48116 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	185,486	8,667		194,153		194,153	4,208	198,361			1
2	Food Purchase		144,790		144,790		144,790	14	144,804			2
3	Housekeeping	56,646	14,634		71,280		71,280	6	71,286			3
4	Laundry	42,317	7,432		49,749		49,749	4	49,753			4
5	Heat and Other Utilities			62,416	62,416		62,416	1,482	63,898			5
6	Maintenance	57,842	25,153	29,295	112,290		112,290	10,907	123,197			6
7	Other (specify):*											7
8	TOTAL General Services	342,291	200,676	91,711	634,678		634,678	16,621	651,299			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200	60	7,260			9
10	Nursing and Medical Records	1,066,073	90,459	19,381	1,175,913		1,175,913		1,175,913			10
10a	Therapy		189,041	230,872	419,913	(204,039)	215,874	110,302	326,176			10a
11	Activities	47,803	1,114		48,917		48,917		48,917			11
12	Social Services	33,316	28	3,002	36,346		36,346		36,346			12
13	CNA Training							604	604			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,147,192	280,642	260,455	1,688,289	(204,039)	1,484,250	110,966	1,595,216			16
	C. General Administration											
17	Administrative	73,857			73,857		73,857	64,032	137,889			17
18	Directors Fees											18
19	Professional Services			163,391	163,391		163,391	(155,737)	7,654			19
20	Dues, Fees, Subscriptions & Promotions			61,935	61,935	(41,063)	20,872	(1,286)	19,586			20
21	Clerical & General Office Expenses	132,727	16,947	9,727	159,401		159,401	141,279	300,680			21
22	Employee Benefits & Payroll Taxes			373,283	373,283		373,283	29,706	402,989			22
23	Inservice Training & Education			378	378		378	369	747			23
24	Travel and Seminar			2,357	2,357		2,357	(358)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			40,812	40,812		40,812	8,705	49,517			26
27	Other (specify):*			1,070	1,070		1,070		1,070			27
28	TOTAL General Administration	206,584	16,947	652,953	876,484	(41,063)	835,421	86,710	922,131			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,696,067	498,265	1,005,119	3,199,451	(245,102)	2,954,349	214,297	3,168,646			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							102,891	102,891			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,309	7,309		7,309	39,985	47,294			32
33	Real Estate Taxes							32,705	32,705			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(327,785)	715			34
35	Rent-Equipment & Vehicles			15,045	15,045		15,045	698	15,743			35
36	Other (specify):*											36
37	TOTAL Ownership			350,854	350,854		350,854	(151,506)	199,348			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					204,039	204,039		204,039			39
40	Barber and Beauty Shops			2,395	2,395		2,395		2,395			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			2,395	2,395	245,102	247,497		247,497			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,696,067	498,265	1,358,368	3,552,700		3,552,700	62,791	3,615,491			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	(972)	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	(558)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,475)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,336)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(4,876)	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)	\$ (21,217)		\$	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)	84,008		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 84,008		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 62,791		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#48116

Report Period Beginning:01/01/11

Ending:12/31/11

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	\$	1
2		2
3		3
4		4
5	0	35
6	0	34
7		7
8		8
9	0	30
10		32
11		11
12		12
13	0	2
14		32
15	0	33
16		24
17	(558)	20
18		18
19		24
20	0	27
21		21
22	(7,336)	19
23		23
24	0	27
25	(4,876)	20
26		26
27		27
28		28
29		33
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	(12,770)

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Gibson City, LLC. # 48116 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	4,208	0	0	0	0	0	0	0	0	4,208	1
2	Food Purchase	0	0	14	0	0	0	0	0	0	0	0	14	2
3	Housekeeping	0	0	6	0	0	0	0	0	0	0	0	6	3
4	Laundry	0	0	4	0	0	0	0	0	0	0	0	4	4
5	Heat and Other Utilities	0	0	1,482	0	0	0	0	0	0	0	0	1,482	5
6	Maintenance	0	0	10,907	0	0	0	0	0	0	0	0	10,907	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	16,621	0	0	0	0	0	0	0	0	16,621	8
	B. Health Care and Programs													
9	Medical Director	0	0	60	0	0	0	0	0	0	0	0	60	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	110,302	0	0	0	0	0	0	0	0	0	110,302	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	604	0	0	0	0	0	0	0	0	604	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	110,302	664	0	0	0	0	0	0	0	0	110,966	16
	C. General Administration													
17	Administrative	0	0	64,032	0	0	0	0	0	0	0	0	64,032	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,336)	(156,055)	7,654	0	0	0	0	0	0	0	0	(155,737)	19
20	Fees, Subscriptions & Promotions	(5,434)	0	4,148	0	0	0	0	0	0	0	0	(1,286)	20
21	Clerical & General Office Expenses	0	0	141,279	0	0	0	0	0	0	0	0	141,279	21
22	Employee Benefits & Payroll Taxes	0	0	29,706	0	0	0	0	0	0	0	0	29,706	22
23	Inservice Training & Education	0	0	369	0	0	0	0	0	0	0	0	369	23
24	Travel and Seminar	(7,475)	0	7,117	0	0	0	0	0	0	0	0	(358)	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	8,705	0	0	0	0	0	0	0	0	8,705	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,245)	(156,055)	263,010	0	0	0	0	0	0	0	0	86,710	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,245)	(45,753)	280,295	0	0	0	0	0	0	0	0	214,297	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Gibson City, LLC. # 48116 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	94,054	0	8,837	0	0	0	0	0	0	0	102,891	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(972)	40,504	0	453	0	0	0	0	0	0	0	39,985	32
33	Real Estate Taxes	0	32,705	0	0	0	0	0	0	0	0	0	32,705	33
34	Rent-Facility & Grounds	0	(328,500)	0	715	0	0	0	0	0	0	0	(327,785)	34
35	Rent-Equipment & Vehicles	0	0	0	698	0	0	0	0	0	0	0	698	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(972)	(161,237)	0	10,703	0	0	0	0	0	0	0	(151,506)	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)	(21,217)	(206,990)	280,295	10,703	0	0	0	0	0	0	0	62,791	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
<u>Heritage Enterprises, Inc.</u>	<u>100</u>	<u>See Page 25</u>				

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	<u>10a</u>	<u>Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>110,302</u>	<u>110,302</u>	2
3	V								3
4	V	<u>19</u>	<u>Adjustment for Related Organization</u>	<u>156,055</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(156,055)</u>	4
5	V								5
6	V	<u>34</u>	<u>Adjustment for Related Organization</u>	<u>328,500</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(328,500)</u>	6
7	V	<u>33</u>	<u>Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>32,705</u>	<u>32,705</u>	7
8	V	<u>32</u>	<u>Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>34,912</u>	<u>34,912</u>	8
9	V	<u>30</u>	<u>Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>94,054</u>	<u>94,054</u>	9
10	V	<u>32</u>	<u>Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>5,592</u>	<u>5,592</u>	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 484,555			\$ 277,565	\$ * (206,990)	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.		\$	4,208	15
16	V	2	Food Purchase					14	16
17	V	3	Housekeeping					6	17
18	V	4	Laundry					4	18
19	V	5	Heat & Other Utilities					1,482	19
20	V	6	Maintenance					10,907	20
21	V	7	Other					0	21
22	V	9	Medical Director					60	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					604	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					64,032	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					7,654	31
32	V	20	Fees, Subscription, Promotions					4,148	32
33	V	21	Clerical & General Office Expenses					141,279	33
34	V	22	Employee Benefits & Payroll Taxes					29,706	34
35	V	23	Inservice Training & Education					369	35
36	V	24	Travel and Seminar					7,117	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					8,705	38
39	Total			\$			\$	0	\$ * 280,295 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					8,837	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					453	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					715	20
21	V	35	Rent-Equipment & Vehicles					698	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	\$ * 10,703 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 Gibson City, LLC. # 48116 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	75	\$ 4,208	1
2	2	Food Purchase	Beds	2,735	26	520	0	75	14	2
3	3	Housekeeping	Beds	2,735	26	215	0	75	6	3
4	4	Laundry	Beds	2,735	26	151	0	75	4	4
5	5	Heat & Other Utilities	Beds	2,735	26	54,054	0	75	1,482	5
6	6	Maintenance	Beds	2,735	26	397,756	75,127	75	10,907	6
7	7	Other	Beds	2,735	26	0	0	75	0	7
8	9	Medical Director	Beds	2,735	26	2,206	0	75	60	8
9	10	Nursing & Medical Records	Beds	2,735	26	0	0	75	0	9
10	11	Activities	Beds	2,735	26	0	0	75	0	10
11	12	Social Service	Beds	2,735	26	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,735	26	22,009	20,793	75	604	12
13	14	Program Transportation	Beds	2,735	26	0	0	75	0	13
14	15	Other	Beds	2,735	26	0	0	75	0	14
15	17	Administrative	Beds	2,735	26	2,335,023	2,335,023	75	64,032	15
16	18	Directors Fees	Beds	2,735	26	0	0	75	0	16
17	19	Professional Services	Beds	2,735	26	279,109	0	75	7,654	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	151,258	0	75	4,148	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	5,151,979	4,517,846	75	141,279	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,083,278	0	75	29,706	20
21	23	Inservice Training & Education	Beds	2,735	26	13,460	0	75	369	21
22	24	Travel and Seminar	Beds	2,735	26	259,533	0	75	7,117	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpractice	Beds	2,735	26	317,454	0	75	8,705	24
25	TOTALS					\$ 10,221,447	\$ 7,101,904		\$ 280,295	25

Facility Name & ID Number Heritage Manor Gibson City, LLC. # 48116 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	\$		75	\$	1
2	30	Depreciation	Beds	2,735	26	322,258		75	8,837	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			75		3
4	32	Interest	Beds	2,735	26	16,517		75	453	4
5	33	Real Estate Taxes	Beds	2,735	26			75		5
6	34	Rent-Facility & Grounds	Beds	2,735	26	26,080		75	715	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	25,461		75	698	7
8	36	Other	Beds	2,735	26			75		8
9	38	Medically Nec Transportation	Beds	2,735	26			75		9
10	39	Ancillary Service Centers	Beds	2,735	26			75		10
11	40	Barber and Beauty Shops	Beds	2,735	26			75		11
12	41	Coffee and Gift Shops	Beds	2,735	26			75		12
13	42	Other	Beds	2,735	26			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					\$ 390,316	\$		\$ 10,703	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			\$	659,809	03/2016	variable	\$ 34,912 1
2	Bank of America		xx	Loan Fees							5,592 2
3											3
4											4
5											5
	Working Capital										
6	Bank of America		xx	Accounts Receivable							7,309 6
7											7
8											8
9	TOTAL Facility Related						\$	659,809			\$ 47,813 9
	B. Non-Facility Related*										
10	Interest Income										(972) 10
11	Allocated Corporate										453 11
12											12
13											13
14	TOTAL Non-Facility Related						\$				\$ (519) 14
15	TOTALS (line 9+line14)						\$	659,809			\$ 47,294 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

1. Real Estate Tax accrual used on 2010 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.)				\$32,705	2
3. Under or (over) accrual (line 2 minus line 1).				\$32,705	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.				\$32,705	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	42,119	8	
		2007	39,581	9	
		2008	39,352	10	
		2009	40,006	11	
		2010	32,705	12	
				FOR BHF USE ONLY	
		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 NAMEHeritage Manor Gibson City, LLC.COUNTYFord

FACILITY IDPH LICENSE NUMBER48116

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) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 091111482001	nursing home	\$ 32,560.00	\$ 32,560.00
2. 091111479017		\$ 145.00	\$ 145.00
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 32,705.00	\$ 32,705.00

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 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: 25,183

B. General Construction Type: Exterior brick Frame wood Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

none

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 20,000	1
2					2
3	TOTALS			\$ 20,000	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	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							8,837	8,837		33
34	Book Depreciation					73,141		73,141			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 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	\$ 73,141		\$ 81,978	\$ 8,837	\$	70

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

12/31/11

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

****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		\$2,490,230	\$73,141		\$81,978	\$8,837		1
2									2
3	Micromatic Scrubber	2011	3,932						3
4	Duro-Last Roofing	2001	9,600						4
5	Trane Rooftop Unit	2001	23,888						5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,527,650	\$73,141		\$81,978	\$8,837		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	\$463,971	\$20,913	\$20,913	\$		\$	71
72	Current Year Purchases	22,737						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$486,708	\$20,913	\$20,913	\$		\$	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	2
		Reference		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)		\$3,034,358
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$94,054
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$102,891
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$8,837
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: \$15,045
- 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 EndingAnnual 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				
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.

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 105,497	\$		\$ 105,497	1
2	Licensed Speech and Language Development Therapist		hrs			6,883			6,883	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			101,043	2,451		103,494	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				186,590		186,590	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					17,449			17,449	13
14	TOTAL			\$		\$ 230,872	\$ 189,041		\$ 419,913	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	\$ 6,034	\$	1
2	Cash-Patient Deposits	8,385		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	481,727		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,527		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,485,270)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (972,597)	\$	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)	\$ (972,597)	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 115,878	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,385		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	127,996		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,373		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)	\$ 253,632	\$	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)	\$ 253,632	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,226,229)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (972,597)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,154,591)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,154,591)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(71,638)	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)	\$ (71,638)	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)	\$ (1,226,229)	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	\$ 3,401,766	1
2	Discounts and Allowances for all Levels	(1,013,905)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,387,861	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	755,531	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 755,531	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	1,317	12
13	Barber and Beauty Care	5,341	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	328,933	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(844)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 334,747	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	972	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 972	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		1,951	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,951	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,481,062	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	634,678	31
32	Health Care	1,688,289	32
33	General Administration	876,484	33
	B. Capital Expense		
34	Ownership	350,854	34
	C. Ancillary Expense		
35	Special Cost Centers	2,395	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)*	\$ 3,552,700	40
41	Income before Income Taxes (line 30 minus line 40)**	(71,638)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (71,638)	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	\$65,397	\$32.44	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,173	8,451	244,029	28.88	3
4	Licensed Practical Nurses	8,588	8,750	207,922	23.76	4
5	CNAs & Orderlies	38,985	41,064	548,725	13.36	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	3,462	3,581	47,803	13.35	10
11	Social Service Workers	1,928	2,016	33,316	16.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,047	16,804	185,486	11.04	15
16	Dishwashers					16
17	Maintenance Workers	4,492	4,637	57,842	12.47	17
18	Housekeepers	5,331	5,496	56,646	10.31	18
19	Laundry	3,058	3,140	42,317	13.48	19
20	Administrator	1,900	2,080	73,857	35.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,306	6,718	132,727	19.76	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)	100,222	104,753	\$1,696,067 *	\$16.19	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		7,200		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		3,002		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$16,542		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	310	\$12,392		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)	310	\$12,392		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Jason Grill			\$ 73,857	Workers' Compensation Insurance	\$	39,561	IDPH License Fee	\$ 0
				Unemployment Compensation Insurance		19,247	Advertising: Employee Recruitment	5,302
				FICA Taxes		129,749	Health Care Worker Background Check	
				Employee Health Insurance		171,777	(Indicate # of checks performed)	647
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*				
						0		3,020
				Other Benefits		12,949	Dues & Subscriptions	5,254
				Central Office Allocation		29,706	License & Fees	4,793
							Central Office Allocation	4,148
							Less: Public Relations Expense	(3,020)
							Non-allowable advertising	(558)
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 73,857					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
	Description		Amount		\$	402,989		\$ 19,586
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
			\$	Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Heritage Operations Group	Mgt		\$ 156,055					
			0					
			0					
							In-State Travel	
								1,843
								0
							Seminar Expense	514
							Central Office	(358)
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
Legal adj to Zero			7,336				TOTAL	\$ 1,999
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL	\$			
			\$ 163,391					

* 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 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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 9,543

(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