

		FOR BHF USE					

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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 Facility ID Number:** 0041525

**Facility Name:** Heritage Manor-Litchfield

**Address:** 628 South Illinois Street Litchfield 62056  
 Number City Zip Code

**County:** Montgomery

**Telephone Number:** ( 217 ) 324-2153 Fax # ( )

**HFS ID Number:** 370909086018

**Date of Initial License for Current Owners:** 1996

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Craig L. Ater</u>	
	(Title) <u>Senior V.P. &amp; CFO</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>( )</u> Fax # <u>( )</u>	

**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-Litchfield# 0041525 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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>102</u>	Skilled (SNF)	<u>102</u>	<u>37,230</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>102</u>	TOTALS	<u>102</u>	<u>37,230</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>14,842</u>	<u>10,275</u>	<u>4,039</u>	<u>29,156</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,842</u>	<u>10,275</u>	<u>4,039</u>	<u>29,156</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.31%

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)

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

G. Do pages 3 &amp; 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 1996

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ 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 4,039Medicare Intermediary Mutual of Omaha

## 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-Litchfield # 0041525 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	147,223	8,826		156,049		156,049	4,502	160,551			1
2	Food Purchase		152,876		152,876		152,876		152,876			2
3	Housekeeping	80,111	16,188		96,299		96,299	5	96,304			3
4	Laundry	37,288	12,879		50,167		50,167		50,167			4
5	Heat and Other Utilities			98,680	98,680		98,680	1,421	100,101			5
6	Maintenance	47,093	29,619	26,581	103,293		103,293	11,908	115,201			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>311,715</b>	<b>220,388</b>	<b>125,261</b>	<b>657,364</b>		<b>657,364</b>	<b>17,836</b>	<b>675,200</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,181,343	60,075	3,909	1,245,327		1,245,327		1,245,327			10
10a	Therapy		179,176	313,470	492,646	(273,032)	219,614	73,608	293,222			10a
11	Activities	43,013	2,062		45,075		45,075		45,075			11
12	Social Services	55,343		1,154	56,497		56,497		56,497			12
13	CNA Training	748	690		1,438		1,438	1,600	3,038			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,280,447</b>	<b>242,003</b>	<b>324,533</b>	<b>1,846,983</b>	<b>(273,032)</b>	<b>1,573,951</b>	<b>75,208</b>	<b>1,649,159</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	72,983			72,983		72,983	69,026	142,009			17
18	Directors Fees							5,124	5,124			18
19	Professional Services			250,863	250,863		250,863	(236,625)	14,238			19
20	Dues, Fees, Subscriptions & Promotions			88,960	88,960	(55,845)	33,115	(15,969)	17,146			20
21	Clerical & General Office Expenses	82,049	8,777	24,694	115,520		115,520	142,477	257,997			21
22	Employee Benefits & Payroll Taxes			358,001	358,001		358,001	37,083	395,084			22
23	Inservice Training & Education			821	821		821	1,178	1,999			23
24	Travel and Seminar			7,824	7,824		7,824	(5,825)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,558	68,558		68,558	1,818	70,376			26
27	Other (specify):*			269	269		269	(100)	169			27
28	<b>TOTAL General Administration</b>	<b>155,032</b>	<b>8,777</b>	<b>799,990</b>	<b>963,799</b>	<b>(55,845)</b>	<b>907,954</b>	<b>(1,813)</b>	<b>906,141</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,747,194</b>	<b>471,168</b>	<b>1,249,784</b>	<b>3,468,146</b>	<b>(328,877)</b>	<b>3,139,269</b>	<b>91,231</b>	<b>3,230,500</b>			<b>29</b>

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

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

Facility Name & ID Number Heritage Manor-Litchfield #0041525 Report Period Beginning: 01/01/05 Ending: 12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			123,046	123,046		123,046	12,083	135,129			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			171,013	171,013		171,013	20,873	191,886			32
33	Real Estate Taxes			60,060	60,060		60,060		60,060			33
34	Rent-Facility & Grounds							6,241	6,241			34
35	Rent-Equipment & Vehicles			10,232	10,232		10,232	(2,032)	8,200			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			364,351	364,351		364,351	37,165	401,516			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					273,032	273,032		273,032			39
40	Barber and Beauty Shops		1,606	19,808	21,414		21,414		21,414			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					55,845	55,845		55,845			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,606	19,808	21,414	328,877	350,291		350,291			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,747,194	472,774	1,633,943	3,853,911		3,853,911	128,396	3,982,307			45

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

Facility Name & ID Number Heritage Manor-Litchfield

# 0041525

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(3,598)	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	(163)	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)		24		16
17	Non-Care Related Fees	(490)	20		17
18	Fines and Penalties				18
19	Entertainment	(15,322)	24		19
20	Contributions	(100)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,765)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(19,812)	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	(23)	23		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (41,273)		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	169,669		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 169,669		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 128,396		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

OHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Litchfield

ID# 0041525

Report Period Beginning: 01/01/05

Ending: 12/31/05

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		(3,598)	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		(490)	20
18			18
19			24
20		(100)	27
21			21
22		(1,765)	19
23			23
24		0	27
25		(19,812)	20
26			26
27			27
28			28
29		(23)	23
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	<b>Total</b>	(25,788)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Litchfield

# 0041525

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	4,502	0	0	0	0	0	0	0	0	4,502	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	5	0	0	0	0	0	0	0	0	5	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,421	0	0	0	0	0	0	0	0	1,421	5
6	Maintenance	0	0	11,908	0	0	0	0	0	0	0	0	11,908	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	17,836	0	0	0	0	0	0	0	0	17,836	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	73,608	0	0	0	0	0	0	0	0	0	73,608	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	1,600	0	0	0	0	0	0	0	0	1,600	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	<b>TOTAL Health Care and Programs</b>	0	73,608	1,600	0	0	0	0	0	0	0	0	75,208	16
	<b>C. General Administration</b>													
17	Administrative	0	0	69,026	0	0	0	0	0	0	0	0	69,026	17
18	Directors Fees	0	0	5,124	0	0	0	0	0	0	0	0	5,124	18
19	Professional Services	(1,765)	(249,098)	14,238	0	0	0	0	0	0	0	0	(236,625)	19
20	Fees, Subscriptions & Promotions	(20,302)	0	4,333	0	0	0	0	0	0	0	0	(15,969)	20
21	Clerical & General Office Expenses	0	0	142,477	0	0	0	0	0	0	0	0	142,477	21
22	Employee Benefits & Payroll Taxes	0	0	37,083	0	0	0	0	0	0	0	0	37,083	22
23	Inservice Training & Education	(23)	0	1,201	0	0	0	0	0	0	0	0	1,178	23
24	Travel and Seminar	(15,322)	0	9,497	0	0	0	0	0	0	0	0	(5,825)	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	1,818	0	0	0	0	0	0	0	0	1,818	26
27	Other (specify):*	(100)	0	0	0	0	0	0	0	0	0	0	(100)	27
28	<b>TOTAL General Administration</b>	(37,512)	(249,098)	284,797	0	0	0	0	0	0	0	0	(1,813)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(37,512)	(175,490)	304,233	0	0	0	0	0	0	0	0	91,231	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Litchfield

# 0041525

Report Period Beginning:

01/01/05 Ending:

12/31/05

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	12,083	0	0	0	0	0	0	0	12,083	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(163)	0	0	21,036	0	0	0	0	0	0	0	20,873	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	6,241	0	0	0	0	0	0	0	6,241	34
35	Rent-Equipment & Vehicles	(3,598)	0	0	1,566	0	0	0	0	0	0	0	(2,032)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,761)</b>	<b>0</b>	<b>0</b>	<b>40,926</b>	<b>0</b>	<b>37,165</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(41,273)</b>	<b>(175,490)</b>	<b>304,233</b>	<b>40,926</b>	<b>0</b>	<b>128,396</b>	<b>45</b>						

Facility Name & ID Number Heritage Manor-Litchfield

# 0041525

Report Period Beginning:

01/01/05

Ending:

12/31/05

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

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

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: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V	10a Adjustment for Related Organization					
3	V						
4	V	19 Adjustment for Related Organization	249,098	Heritage Enterprises, Inc.	100.00%		(249,098)
5	V						
6	V	10a Adjustment for Related Organization	178,651	GreenTree Pharmacy	100.00%	252,259	73,608
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 427,749			\$ 252,259	\$ * (175,490)

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

Facility Name & ID Number Heritage Manor-Litchfield# 0041525Report Period Beginning: 01/01/05Ending: 12/31/05

## 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.	100.00%	\$ 4,502	\$ 4,502	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				5	5	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,421	1,421	19
20	V	6 Maintenance				11,908	11,908	20
21	V	7 Other				0		21
22	V	9 Medical Director				0		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				1,600	1,600	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				69,026	69,026	29
30	V	18 Directors Fees				5,124	5,124	30
31	V	19 Professional Services				14,238	14,238	31
32	V	20 Fees, Subscription, Promotions				4,333	4,333	32
33	V	21 Clerical & General Office Expenses				142,477	142,477	33
34	V	22 Employee Benefits & Payroll Taxes				37,083	37,083	34
35	V	23 Inservice Training & Education				1,201	1,201	35
36	V	24 Travel and Seminar				9,497	9,497	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				1,818	1,818	38
39	Total		\$			\$ 304,233	\$ * 304,233	39

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

Facility Name & ID Number Heritage Manor-Litchfield# 0041525Report Period Beginning: 01/01/05Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	27	Other	\$	Heritage Enterprises, Inc.	100.00%	\$	0	15
16	V	30	Depreciation					12,083	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					21,036	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,241	20
21	V	35	Rent-Equipment & Vehicles					1,566	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	\$ * 40,926 39

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

Facility Name & ID Number Heritage Manor-Litchfield # 0041525 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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	Susie Jefferson	Director	Management	15.86				Salary/BOD	\$ 15,574	Ln 17 & 18	1
2	Estate of Tom Jefferson			16.21				Salary/BOD	0	Ln 17 & 18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	17,467	Ln 17 & 18	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Salary/BOD	10,401	Ln 17 & 18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	13,554	Ln 17 & 18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	6,688	Ln 17 & 18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	7,496	Ln 17 & 18	7
8	<b>Ben Hart</b>	<b>Vice President</b>	Management	3.20							8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 71,180		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-Litchfield

# 0041525

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization Heritage Enterprises  
 Street Address 115 W. Jefferson  
 City / State / Zip Code Bloomington, IL  
 Phone Number ( )  
 Fax Number ( )

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	2,612	25	\$ 115,289	\$ 115,276	102	\$ 4,502	1
2	2	Food Purchase	Beds	2,612	25	7	0	102	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	102	5	3
4	4	Laundry	Beds	2,612	25	0	0	102	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	102	1,421	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	102	11,908	6
7	7	Other	Beds	2,612	25	0	0	102	0	7
8	9	Medical Director	Beds	2,612	25	0	0	102	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	102	0	9
10	11	Activities	Beds	2,612	25	0	0	102	0	10
11	12	Social Service	Beds	2,612	25	0	0	102	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	102	1,600	12
13	14	Program Transportation	Beds	2,612	25	0	0	102	0	13
14	15	Other	Beds	2,612	25	0	0	102	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	102	69,026	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	102	5,124	16
17	19	Professional Services	Beds	2,612	25	364,592	0	102	14,238	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	102	4,333	18
19	21	Clerical & General Office Expense	Beds	2,612	25	3,648,522	3,309,912	102	142,477	19
20	22	Employee Benefits & Payroll Tax	Beds	2,612	25	949,625	0	102	37,083	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	102	1,201	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	102	9,497	22
23	25	Other Admin. Staff Transportatio	Beds	2,612	25	0	0	102	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	102	1,818	24
25	TOTALS					\$ 7,790,758	\$ 5,312,885		\$ 304,233	25

Facility Name & ID Number Heritage Manor-Litchfield

# 0041525

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	2,612	25	\$	102	\$	1
2	30	Depreciation	Beds	2,612	25	309,426	102	12,083	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25		102		3
4	32	Interest	Beds	2,612	25	538,695	102	21,036	4
5	33	Real Estate Taxes	Beds	2,612	25		102		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809	102	6,241	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093	102	1,566	7
8	36	Other	Beds	2,612	25		102		8
9	38	Medically Nec Transportation	Beds	2,612	25		102		9
10	39	Ancillary Service Centers	Beds	2,612	25		102		10
11	40	Barber and Beauty Shops	Beds	2,612	25		102		11
12	41	Coffee and Gift Shops	Beds	2,612	25		102		12
13	42	Other	Beds	2,612	25		102		13
14							102		14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,048,023	\$		\$ 40,926	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Busey Bank		xx	Mortgage	4640 plus Int	01/15/99	\$	\$ 2,404,956	01/15/06	variable	\$ 151,722	1								
2	Busey Bank		xx	Mortgage							2,204	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Central Office Allocation		xx	Working Capital							17,087	6								
7	Central Office Allocation		xx	Working Capital								7								
8												8								
9	<b>TOTAL Facility Related</b>						\$	\$ 2,404,956			\$ 171,013	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(163)	10								
11												11								
12	Central Office Allocation										21,036	12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 20,873	14								
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 2,404,956			\$ 191,886	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	<b>67,859</b>	<b>1</b>
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.)		\$	<b>62,400</b>			<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(5,459)</b>			<b>3</b>
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>65,519</b>			<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$				<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$				<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>60,060</b>			<b>7</b>
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:						
2000	<u>49,200</u>	<u>8</u>				
2001	<u>53,545</u>	<u>9</u>				
2002	<u>60,298</u>	<u>10</u>				
2003	<u>55,799</u>	<u>11</u>				
2004	<u>65,556</u>	<u>12</u>				
			<b>FOR OHF USE ONLY</b>			
			<b>13</b>	FROM R. E. TAX STATEMENT FOR 2004	\$	<b>13</b>
			<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
			<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
			<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor-Litchfield COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0041525

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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>16-001-848-00</u>	<u>Heritage Manor-Litchfield</u>	\$ <u>2,821.00</u>	\$ <u>2,821.00</u>
2. <u>16-001-698-01</u>	<u>_____</u>	\$ <u>175.00</u>	\$ <u>175.00</u>
3. <u>16-001-691-00</u>	<u>_____</u>	\$ <u>59,404.00</u>	\$ <u>59,404.00</u>
4. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
5. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
6. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
7. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
8. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
9. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
10. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>62,400.00</u>	\$ <u>62,400.00</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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Heritage Manor-Litchfield

# 0041525 Report Period Beginning:

01/01/05 Ending:

12/31/05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 16,802 B. General Construction Type: Exterior brick/wood 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				\$ <u>19,316</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>19,316</u>	3

Facility Name & ID Number Heritage Manor-Litchfield

# 0041525

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	102				\$ 3,364,350	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9		Symmons Mixing Valve		1997	2,000						9
10		Boiler		1997	5,612						10
11		Dinning Room Roof Repair		1997	2,755						11
12		Roof Repair		1997	3,280						12
13											13
14		Laundry Room Central Air		1996	3,019						14
15		Heritage Manor Sign		1996	2,173						15
16											16
17		Roof		1998	60,674						17
18		Booster Heater		1998	1,717						18
19		Heat/Cool Units		1998	3,433						19
20		Garbage Disposal		1998	730						20
21											21
22											22
23											23
24											24
25											25
26				1999	920						26
27		Recirculating Pump		1999	2,046						27
28		Plumbing repairs/Replacement		1999	10,045						28
29		Carpet		1999	2,335						29
30		Interior Painting--Materials and Labor									30
31		Water Heater									31
32											32
33											33
34		C/O Allocation						12,083	12,083		34
35		Book Depreciation				100,827		100,827		887,049	35
36											36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Heritage Manor-Litchfield

# 0041525

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	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	Rooftop A/C Unit	2000	\$ 3,348	\$		\$	\$	\$	37
38	Blacktop Walkway	2000	2,250						38
39	Gazebo	2000	7,675						39
40									40
41	A/C Unit	2001	3,879						41
42	Gazebo	2001	981						42
43									43
44	A/C Unit	2002	1,453						44
45	A/C Unit	2002	3,120						45
46	Disposal	2002	794						46
47	Boiler	2002	1,453						47
48									48
49	A/C Unit	2003	3,458						49
50	A/C Unit	2003	833						50
51	A/C Unit	2003	2,440						51
52	A/C Unit	2003	4,542						52
53	Food Processor	2003	1,227						53
54	Ansul System	2003	1,271						54
55									55
56	Heat/Cool Units	2004	7,437						56
57	Resurface Parking Lot	2004	30,570						57
58	Roof Repair	2004	6,110						58
59	Rooftop A/C Unit	2004	3,479						59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,551,409	\$ 100,827		\$ 112,910	\$ 12,083	\$ 887,049	70

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

Facility Name & ID Number Heritage Manor-Litchfield

# 0041525

Report Period Beginning:

01/01/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	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 12A, Carried Forward		\$ 3,551,409	\$ 100,827		\$ 112,910	\$ 12,083	\$ 887,049	1
2									2
3	Disposal	2005	842						3
4	Electrical Service	2005	8,421						4
5	A/C Units	2005	5,786						5
6	Boiler	2005	3,863						6
7	Exterior Lights	2005	1,095						7
8	Interior Remodel-- paint, wallcoverings	2005	49,155						8
9	Roof	2005	70,055						9
10	Exterior Door	2005	1,158						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)		\$ 3,691,784	\$ 100,827		\$ 112,910	\$ 12,083	\$ 887,049	34

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

Facility Name & ID Number Heritage Manor-Litchfield # 0041525 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 354,300	\$ 22,219	\$ 22,219	\$		\$ 303,562	71
72	Current Year Purchases	45,205						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 399,505	\$ 22,219	\$ 22,219	\$		\$ 303,562	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,110,605	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 123,046	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 135,129	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,083	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,190,611	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	<b>TOTAL</b>				\$ _____			7

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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 8,200 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	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		690		690
3	Classroom Wages (a)		748		748
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,438	\$	\$ 1,438
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,438		

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heritage Manor-Litchfield# 0041525

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

	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	\$		\$ 131,021	\$		\$ 131,021	1
2	Licensed Speech and Language Development Therapist		hrs			20,171			20,171	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			141,505	525		142,030	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				252,259		252,259	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					20,773			20,773	13
14	TOTAL			\$		\$ 313,470	\$ 252,784		\$ 566,254	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Manor-Litchfield# 0041525Report Period Beginning: 01/01/05

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12/31/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 22,017	\$	1
2	Cash-Patient Deposits	7,173		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	431,678		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,813		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,016,775		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,511,456	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	19,316		13
14	Buildings, at Historical Cost	3,691,785		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	399,505		16
17	Accumulated Depreciation (book methods)	(1,190,611)		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):	6,979		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,926,974	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,438,430	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 54,414	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,173		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	210,326		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,564		31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,519		32
33	Accrued Interest Payable	15,492		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 354,488	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,404,956		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,404,956	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,759,444	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,678,986	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,438,430	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,391,649	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,391,649	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	287,337	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)	\$ 287,337	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,678,986	24 *

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

Facility Name & ID Number Heritage Manor-Litchfield# 0041525Report Period Beginning: 01/01/05Ending: 12/31/05**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,052,947	1
2	Discounts and Allowances for all Levels	(1,088,345)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,964,602	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	808,984	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 808,984	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,302	12
13	Barber and Beauty Care	51,092	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	314,021	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	84	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 367,499	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	163	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 163	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,141,248	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	657,364	31
32	Health Care	1,846,983	32
33	General Administration	963,799	33
<b>B. Capital Expense</b>			
34	Ownership	364,351	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	21,414	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,853,911	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	287,337	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 287,337	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor-Litchfield

# 0041525

Report Period Beginning:

01/01/05

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**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	1,802	1,950	\$ 38,220	\$ 19.60	1
2	Assistant Director of Nursing	432	450	13,422	29.83	2
3	Registered Nurses	2,725	2,725	63,271	23.22	3
4	Licensed Practical Nurses	15,245	16,477	269,239	16.34	4
5	CNAs & Orderlies	74,124	80,401	770,881	9.59	5
6	CNA Trainees	80	80	748	9.35	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,956	2,076	26,310	12.67	8
9	Activity Director					9
10	Activity Assistants	3,068	3,366	43,013	12.78	10
11	Social Service Workers	3,860	4,296	55,343	12.88	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,447	17,347	147,223	8.49	15
16	Dishwashers					16
17	Maintenance Workers	3,570	3,988	47,093	11.81	17
18	Housekeepers	9,452	10,245	80,111	7.82	18
19	Laundry	4,895	5,089	37,288	7.33	19
20	Administrator	1,900	2,080	72,983	35.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,576	6,240	82,049	13.15	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)	145,132	156,810	\$ 1,747,194 *	\$ 11.14	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		6,000		36
37	Medical Records Consultant		629		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,586		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		1,154		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 10,369		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





Facility Name &amp; ID Number Heritage Manor-Litchfield

**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 Healthcare 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 xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,845  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 1,229
- (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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available
- (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 \$2500, 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.



Name	Title	Function	Total Pay	Costed by Mgmt	Total # Beds	Facility # Beds	Non-Nursing Home	Nursing Home	This Facility
### Susie Jefferson	Director	Management	418,245	418,245	2,612	102	3,471,750	71,391,262	
### Tom Jefferson	Secretary	Management	0	0					
### Craig Hart	Chairman	Management	469,049	469,049			21,752	447,297	17,467
### Cheryl Lowney	Executive Vice President	Management	279,290	279,290			12,952	266,338	10,401
### Steve Wannemache	President	Management	363,969	363,969			16,879	347,090	13,554
### Connie Hoselton	Sr Vice President	Management	179,584	179,584			8,328	171,256	6,688
### Craig Ater	Sr Vice President	Management	201,279	201,279			9,334	191,945	7,496
Ben Hart			79,758	79,758			3,699	76,059	2,970
13			1,991,174	1,991,174				1,898,834	74,150