

Facility Name & ID Number Heritage Manor-Chillicothe# 0048868 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>110</u>	Skilled (SNF)	<u>110</u>	<u>40,150</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>110</u>	TOTALS	<u>110</u>	<u>40,150</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,844</u>	<u>10,133</u>	<u>4,324</u>	<u>36,301</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,844</u>	<u>10,133</u>	<u>4,324</u>	<u>36,301</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.41%

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 & 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 07/2007

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

YES Date 07/2007 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 4,324Medicare 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-Chillicothe # 0048868 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	220,254	17,955		238,209		238,209	6,055	244,264		1
2	Food Purchase		221,217		221,217		221,217		221,217		2
3	Housekeeping	105,347	14,951		120,298		120,298	22	120,320		3
4	Laundry	45,590	9,408		54,998		54,998		54,998		4
5	Heat and Other Utilities			133,883	133,883		133,883	2,131	136,014		5
6	Maintenance	64,440	66,495	51,816	182,751		182,751	15,163	197,914		6
7	Other (specify):*										7
8	TOTAL General Services	435,631	330,026	185,699	951,356		951,356	23,371	974,727		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	2,472	14,472		9
10	Nursing and Medical Records	1,807,846	186,226	63,511	2,057,583		2,057,583		2,057,583		10
10a	Therapy		352,882	695,378	1,048,260	(368,779)	679,481	251,135	930,616		10a
11	Activities	68,632	4,482		73,114		73,114	1,592	74,706		11
12	Social Services	23,125		3,627	26,752		26,752		26,752		12
13	CNA Training	9,955	360		10,315		10,315	1,258	11,573		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,909,558	543,950	774,516	3,228,024	(368,779)	2,859,245	256,457	3,115,702		16
	C. General Administration										
17	Administrative	83,266			83,266		83,266	76,669	159,935		17
18	Directors Fees							8,167	8,167		18
19	Professional Services			277,270	277,270		277,270	(268,950)	8,320		19
20	Dues, Fees, Subscriptions & Promotions			169,835	169,835	(60,225)	109,610	(58,107)	51,503		20
21	Clerical & General Office Expenses	185,650	33,853	15,314	234,817		234,817	172,032	406,849		21
22	Employee Benefits & Payroll Taxes			512,403	512,403		512,403	35,157	547,560		22
23	Inservice Training & Education			4,274	4,274		4,274	(2,275)	1,999		23
24	Travel and Seminar			7,069	7,069		7,069	(5,070)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			58,359	58,359		58,359	12,224	70,583		26
27	Other (specify):*			19,415	19,415		19,415	(19,340)	75		27
28	TOTAL General Administration	268,916	33,853	1,063,939	1,366,708	(60,225)	1,306,483	(49,493)	1,256,990		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,614,105	907,829	2,024,154	5,546,088	(429,004)	5,117,084	230,335	5,347,419		29

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

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

Facility Name & ID Number Heritage Manor-Chillicothe #0048868 Report Period Beginning: 01/01/08 Ending: 12/31/08

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							199,679	199,679			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,448	16,448		16,448	255,849	272,297			32
33	Real Estate Taxes							75,324	75,324			33
34	Rent-Facility & Grounds			481,800	481,800		481,800	(469,869)	11,931			34
35	Rent-Equipment & Vehicles			7,627	7,627		7,627	2,034	9,661			35
36	Other (specify):*											36
37	TOTAL Ownership			505,875	505,875		505,875	63,017	568,892			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					368,779	368,779		368,779			39
40	Barber and Beauty Shops			7,595	7,595		7,595		7,595			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,225	60,225		60,225			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			7,595	7,595	429,004	436,599		436,599			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,614,105	907,829	2,537,624	6,059,558		6,059,558	293,352	6,352,910			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-Chillicothe

0048868

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	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	(3,453)	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)	(3,026)	23		16
17	Non-Care Related Fees	(1,847)	20		17
18	Fines and Penalties				18
19	Entertainment	(16,078)	24		19
20	Contributions	(1,340)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(16,273)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)	27		24
25	Fund Raising, Advertising and Promotional	(63,662)	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		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (123,679)		\$	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)	417,031		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 417,031		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ 293,352		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Chillicothe

ID# 0048868

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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		(3,026)	23
17		(1,847)	20
18			18
19			24
20		(1,340)	27
21			21
22		(16,273)	19
23			23
24		(18,000)	27
25		(63,662)	20
26			26
27			27
28			28
29		0	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	(104,148)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Chillicothe# 0048868

Report Period Beginning:

01/01/08

Ending:

12/31/08**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	6,055	0	0	0	0	0	0	0	0	6,055	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	22	0	0	0	0	0	0	0	0	22	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,131	0	0	0	0	0	0	0	0	2,131	5
6	Maintenance	0	0	15,163	0	0	0	0	0	0	0	0	15,163	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	23,371	0	0	0	0	0	0	0	0	23,371	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,472	0	0	0	0	0	0	0	0	2,472	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	251,135	0	0	0	0	0	0	0	0	0	251,135	10a
11	Activities	0	0	1,592	0	0	0	0	0	0	0	0	1,592	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,258	0	0	0	0	0	0	0	0	1,258	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	251,135	5,322	0	0	0	0	0	0	0	0	256,457	16
	C. General Administration													
17	Administrative	0	0	76,669	0	0	0	0	0	0	0	0	76,669	17
18	Directors Fees	0	0	8,167	0	0	0	0	0	0	0	0	8,167	18
19	Professional Services	(16,273)	(260,997)	8,320	0	0	0	0	0	0	0	0	(268,950)	19
20	Fees, Subscriptions & Promotions	(65,509)	0	7,402	0	0	0	0	0	0	0	0	(58,107)	20
21	Clerical & General Office Expenses	0	0	172,032	0	0	0	0	0	0	0	0	172,032	21
22	Employee Benefits & Payroll Taxes	0	0	35,157	0	0	0	0	0	0	0	0	35,157	22
23	Inservice Training & Education	(3,026)	0	751	0	0	0	0	0	0	0	0	(2,275)	23
24	Travel and Seminar	(16,078)	0	11,008	0	0	0	0	0	0	0	0	(5,070)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	12,224	0	0	0	0	0	0	0	0	12,224	26
27	Other (specify):*	(19,340)	0	0	0	0	0	0	0	0	0	0	(19,340)	27
28	TOTAL General Administration	(120,226)	(260,997)	331,730	0	0	0	0	0	0	0	0	(49,493)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(120,226)	(9,862)	360,423	0	0	0	0	0	0	0	0	230,335	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	187,925	0	11,754	0	0	0	0	0	0	0	199,679	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,453)	252,229	0	7,073	0	0	0	0	0	0	0	255,849	32
33	Real Estate Taxes	0	75,324	0	0	0	0	0	0	0	0	0	75,324	33
34	Rent-Facility & Grounds	0	(481,800)	0	11,931	0	0	0	0	0	0	0	(469,869)	34
35	Rent-Equipment & Vehicles	0	0	0	2,034	0	0	0	0	0	0	0	2,034	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,453)	33,678	0	32,792	0	63,017	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)	(123,679)	23,816	360,423	32,792	0	293,352	45						

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:
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		\$			\$	\$
2	V	10a	Adjustment for Related Organization	GreenTree Pharmacy		251,135	251,135
3	V						
4	V	19	Adjustment for Related Organization	Heritage Operations Group, LLC	0.00%		(260,997)
5	V						
6	V	34	Adjustment for Related Organization	Heritage Manor Real Estate, LLC	0.00%		(481,800)
7	V	33	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		75,324	75,324
8	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		245,898	245,898
9	V	30	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		187,925	187,925
10	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		6,331	6,331
11	V						
12	V						
13	V						
14	Total		\$ 742,797			\$ 766,613	\$ * 23,816

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

Facility Name & ID Number Heritage Manor-Chillicothe# 0048868Report Period Beginning: 01/01/08Ending: 12/31/08

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.	0.00%	\$ 6,055	\$ 6,055	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				22	22	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				2,131	2,131	19
20	V	6 Maintenance				15,163	15,163	20
21	V	7 Other				0		21
22	V	9 Medical Director				2,472	2,472	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,592	1,592	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				1,258	1,258	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				76,669	76,669	29
30	V	18 Directors Fees				8,167	8,167	30
31	V	19 Professional Services				8,320	8,320	31
32	V	20 Fees, Subscription, Promotions				7,402	7,402	32
33	V	21 Clerical & General Office Expenses				172,032	172,032	33
34	V	22 Employee Benefits & Payroll Taxes				35,157	35,157	34
35	V	23 Inservice Training & Education				751	751	35
36	V	24 Travel and Seminar				11,008	11,008	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				12,224	12,224	38
39	Total		\$			\$ 360,423	\$ * 360,423	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	\$		0.00%	\$ 0	\$	15
16	V	30 Depreciation				11,754	11,754	16
17	V	31 Amortization of Pre-Op & Org				0		17
18	V	32 Interest				7,073	7,073	18
19	V	33 Real Estate Taxes				0		19
20	V	34 Rent-Facility & Grounds				11,931	11,931	20
21	V	35 Rent-Equipment & Vehicles				2,034	2,034	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		\$			\$ 32,792	\$ *	32,792 39

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

Facility Name & ID Number Heritage Manor-Chillicothe # 0048868 Report Period Beginning: 01/01/08 Ending: 12/31/08

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					\$ 8,167	18/7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,167		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-Chillicothe

0048868

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 Operations Group
 Street Address box 3188
 City / State / Zip Code Bloomington, IL 61701
 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	2,634	25	\$ 144,981	\$ 144,706	110	\$ 6,055	1
2	2	Food Purchase	Beds	2,634	25	0	0	110	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	110	22	3
4	4	Laundry	Beds	2,634	25	0	0	110	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	110	2,131	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	110	15,163	6
7	7	Other	Beds	2,634	25	0	0	110	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	110	2,472	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	110	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	110	1,592	10
11	12	Social Service	Beds	2,634	25	0	0	110	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	110	1,258	12
13	14	Program Transportation	Beds	2,634	25	0	0	110	0	13
14	15	Other	Beds	2,634	25	0	0	110	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	110	76,669	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	110	8,167	16
17	19	Professional Services	Beds	2,634	25	199,226	0	110	8,320	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	110	7,402	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	110	172,032	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	110	35,157	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	110	751	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	110	11,008	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	110	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	110	12,224	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 360,423	25

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	2,634	110	\$	\$	110	\$	1
2	30	Depreciation	Beds	2,634	110	281,453		110	11,754	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	110			110		3
4	32	Interest	Beds	2,634	110	169,367		110	7,073	4
5	33	Real Estate Taxes	Beds	2,634	110			110		5
6	34	Rent-Facility & Grounds	Beds	2,634	110	285,687		110	11,931	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	110	48,715		110	2,034	7
8	36	Other	Beds	2,634	110			110		8
9	38	Medically Nec Transportation	Beds	2,634	110			110		9
10	39	Ancillary Service Centers	Beds	2,634	110			110		10
11	40	Barber and Beauty Shops	Beds	2,634	110			110		11
12	41	Coffee and Gift Shops	Beds	2,634	110			110		12
13	42	Other	Beds	2,634	110			110		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					\$ 785,222	\$		\$ 32,792	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	Busey Bank		xx	Mortgage			\$	\$ 3,727,832	07/15	5.9500	\$ 243,144	1								
2	Busey Bank		xx	Loan Fees							6,331	2								
3	Alpha Bank		xx	Van				33,023		5.5000	2,754	3								
4												4								
5												5								
Working Capital																				
6	Bank of America		xx	Accounts Receivable							16,448	6								
7												7								
8												8								
9	TOTAL Facility Related						\$	\$ 3,760,855			\$ 268,677	9								
B. Non-Facility Related*																				
10	Interest Income										(3,453)	10								
11	Allocated Corporate										7,073	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 3,620	14								
15	TOTALS (line 9+line14)						\$	\$ 3,760,855			\$ 272,297	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none 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 2007 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.)			\$ 75,324	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 75,324	3
4. Real Estate Tax accrual used for 2008 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.			\$ 75,324	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	40,917	8		
2004	36,943	9		
2005	42,119	10		
2006	39,581	11		
2007	75,324	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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.

Facility Name & ID Number Heritage Manor-Chillicothe

0048868 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,331 B. General Construction Type: Exterior brick Frame wood Number of Stories _____

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>129,000</u>	1
2					2
3	TOTALS			\$ <u>129,000</u>	3

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	110				\$ 3,301,403	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Awning			1998	2,334						9
10	Heritage Sign			1998	1,860						10
11	Chiller Replacement			1998	54,444						11
12											12
13	Interior Remodel--Materials			1999	154,576						13
14				1999							14
15	Interior Remodel--Professional Fees			1999	24,247						15
16											16
17	Water Heater controls			2000	1,347						17
18	Water Heater			2000	57,254						18
19	Door Locks			2000	1,997						19
20	Heat / Cool Fan			2000	1,598						20
21	Fire Alarm System			2000	4,400						21
22	Alzheimer Unit -- Professional Fees			2000	25,115						22
23	Interior Remodel--Materials (see attached)			2000	93,951						23
24	Interior Remodel--Labor (see attached)			2000	23,130						24
25	Interior Remodel--Professional Fees (see attached)			2000	5,762						25
26											26
27	Water Softener			2001	4,246						27
28	Boiler			2001	29,350						28
29	Door Holders			2001	654						29
30	Alzheimer Unit -- Professional Fees			2001	4,660						30
31											31
32											32
33											33
34	C/O Allocation							11,754	11,754		34
35	Book Depreciation					149,758		149,758		1,282,184	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	Carpet	2002	\$ 2,373	\$		\$	\$	\$	37
38	Compressor	2002	1,164						38
39	Compressor	2002	7,234						39
40	Windows	2002	1,722						40
41									41
42	Storge Tank	2003	737						42
43	In-sink Aerator	2003	810						43
44	Boiler	2003	16,393						44
45	Carpet	2003	2,839						45
46									46
47	Smoke detectors	2004	2,285						47
48	Dinning Room Waitress	2004	2,617						48
49	Parking Lot Sealcoat	2004	4,926						49
50	Boiler Pipe	2004	3,775						50
51	Auto Trans Switch	2004	16,847						51
52	Day Room	2004	1,778						52
53									53
54	Day Room	2005	8,753						54
55	Boiler	2005	19,619						55
56	Fire Alarm	2005	1,628						56
57	Resident Room Carpet	2005	698						57
58	Security System	2005	6,393						58
59	Breaker Replacement	2005	1,980						59
60	Condenser	2005	1,118						60
61	Roof	2005	188,466						61
62	Wiring	2005	820						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,087,303	\$ 149,758		\$ 161,512	\$ 11,754	\$ 1,282,184	70

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

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 4,087,303	\$ 149,758		\$ 161,512	\$ 11,754	\$ 1,282,184	1
2	Heat pump	2006	5,669						2
3	Boiler	2006	72,981						3
4	fire Alarm	2006	3,553						4
5	Roof	2006	1,300						5
6	Kitchen remodel	2006	4,623						6
7	Carpet	2006	1,139						7
8	Condensing Unit	2006	2,000						8
9	East Wing Dinning Room Remodel	2006	5,228						9
10									10
11	East Wing Remodel-- paint, floors	2007	25,094						11
12	Boiler	2007	970						12
13	Fire Alarm	2007	924						13
14	Generator	2007	1,675						14
15	Code Alert	2007	4,622						15
16	Fence	2007	3,089						16
17	Landscapping	2007	1,500						17
18	Parking Lot sealer	2007	5,000						18
19	Generator	2007	8,260						19
20	Heat pump	2007	21,969						20
21	Water Line	2007	1,296						21
22									22
23	East Wing Remodel-- paint, floors	2008	66,928						23
24	Sprinkler Backflow	2008	4,360						24
25	Heat pump	2008	16,046						25
26	Soiled Utility/Med Room	2008	2,622						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,348,151	\$ 149,758		\$ 161,512	\$ 11,754	\$ 1,282,184	34

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

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 4,348,151	\$ 149,758		\$ 161,512	\$ 11,754	\$ 1,282,184	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,348,151	\$ 149,758		\$ 161,512	\$ 11,754	\$ 1,282,184	34

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

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 4,348,151	\$ 149,758		\$ 161,512	\$ 11,754	\$ 1,282,184	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
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,348,151	\$ 149,758		\$ 161,512	\$ 11,754	\$ 1,282,184	34

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

Facility Name & ID Number Heritage Manor-Chillicothe # 0048868 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 551,795	\$ 38,167	\$ 38,167	\$		\$ 430,676	71
72	Current Year Purchases	19,564						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 571,359	\$ 38,167	\$ 38,167	\$		\$ 430,676	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)	\$ 5,048,510	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 187,925	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 199,679	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,754	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,712,860	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 7,627 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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		360		360
3	Classroom Wages (a)				
4	Clinical Wages (b)		9,955		9,955
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 10,315	\$	\$ 10,315
10	SUM OF line 9, col. 1 and 2 (e)	\$	10,315		

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Heritage Manor-Chillicothe# 0048868

Report Period Beginning:

01/01/08

Ending:

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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	\$		\$ 225,889	\$		\$ 225,889	1
2	Licensed Speech and Language Development Therapist		hrs			119,370			119,370	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			330,669	3,553		334,222	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				349,329		349,329	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					19,450			19,450	13
14	TOTAL			\$		\$ 695,378	\$ 352,882		\$ 1,048,260	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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 26,220	\$	1
2	Cash-Patient Deposits	19,735		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,060,069		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,398		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(572,859)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 538,563	\$	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)	\$ 538,563	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 197,726	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,735		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	224,618		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,136		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	<u>IPA Tax</u>	15,180		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 458,395	\$	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)	\$ 458,395	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 80,168	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 538,563	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (309,872)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (309,872)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	390,040	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)	\$ 390,040	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)	\$ 80,168	24 *

* This must agree with page 17, line 47.

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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	\$ 6,182,767	1
2	Discounts and Allowances for all Levels	(2,803,283)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,379,484	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,457,875	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,457,875	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	1,663	12
13	Barber and Beauty Care	7,706	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	599,288	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	129	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 608,786	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,453	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,453	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,449,598	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	951,356	31
32	Health Care	3,228,024	32
33	General Administration	1,366,708	33
B. Capital Expense			
34	Ownership	505,875	34
C. Ancillary Expense			
35	Special Cost Centers	7,595	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)*	\$ 6,059,558	40
41	Income before Income Taxes (line 30 minus line 40)**	390,040	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 390,040	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-Chillicothe

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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	1,771	1,841	\$ 53,837	\$ 29.24	1
2	Assistant Director of Nursing	2,191	2,406	59,960	24.92	2
3	Registered Nurses	7,370	7,513	198,984	26.49	3
4	Licensed Practical Nurses	17,796	18,884	466,570	24.71	4
5	CNAs & Orderlies	66,622	71,377	948,207	13.28	5
6	CNA Trainees	1,000	1,000	9,955	9.96	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,774	4,317	80,288	18.60	8
9	Activity Director					9
10	Activity Assistants	5,137	5,861	68,632	11.71	10
11	Social Service Workers	1,809	2,030	23,125	11.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,700	20,952	220,254	10.51	15
16	Dishwashers					16
17	Maintenance Workers	3,483	3,909	64,440	16.49	17
18	Housekeepers	10,135	10,853	105,347	9.71	18
19	Laundry	4,722	4,974	45,590	9.17	19
20	Administrator	1,900	2,080	83,266	40.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,059	11,373	185,650	16.32	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)	157,469	169,370	\$ 2,614,105 *	\$ 15.43	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	12,000		36
37	Medical Records Consultant	1,750		37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,300		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	3,627		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 20,677		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	52	\$ 2,090	50
51	Licensed Practical Nurses	1,586	55,515	51
52	Certified Nurse Assistants/Aides		0	52
53	TOTAL (lines 50 - 52)	1,638	\$ 57,605	53

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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES x NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Heritage Manor Chillicothe 43885 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,225
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. \$ 3,070
- (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? _____ If no, please explain. Not available at this date
- (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.

