

Facility Name & ID Number Heritage Manor-Dwight

0037853 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>92</u>	Skilled (SNF)	<u>92</u>	<u>33,580</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>92</u>	TOTALS	<u>92</u>	<u>33,580</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>14,338</u>	<u>8,497</u>	<u>4,409</u>	<u>27,244</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>14,338</u>	<u>8,497</u>	<u>4,409</u>	<u>27,244</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.13%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

none

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started 2/2007

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

YES Date 2/2007 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 4,409

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Manor-Dwight # 0037853 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	207,586	9,192		216,778		216,778	5,064	221,842		1
2	Food Purchase		161,231		161,231		161,231		161,231		2
3	Housekeeping	101,285	15,776		117,061		117,061	19	117,080		3
4	Laundry	51,055	10,452		61,507		61,507		61,507		4
5	Heat and Other Utilities			152,942	152,942		152,942	1,782	154,724		5
6	Maintenance	61,089	42,530	37,098	140,717		140,717	12,682	153,399		6
7	Other (specify):*										7
8	TOTAL General Services	421,015	239,181	190,040	850,236		850,236	19,547	869,783		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600	2,067	11,667		9
10	Nursing and Medical Records	1,166,044	137,014	138,696	1,441,754		1,441,754		1,441,754		10
10a	Therapy		302,503	389,327	691,830	(333,656)	358,174	81,224	439,398		10a
11	Activities	64,810	6,018		70,828		70,828	1,331	72,159		11
12	Social Services	60,122		2,110	62,232		62,232		62,232		12
13	CNA Training	1,299	739		2,038		2,038	1,052	3,090		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,292,275	446,274	539,733	2,278,282	(333,656)	1,944,626	85,674	2,030,300		16
	C. General Administration										
17	Administrative	81,110			81,110		81,110	64,123	145,233		17
18	Directors Fees							6,830	6,830		18
19	Professional Services			208,006	208,006		208,006	(201,047)	6,959		19
20	Dues, Fees, Subscriptions & Promotions			119,881	119,881	(50,370)	69,511	(42,937)	26,574		20
21	Clerical & General Office Expenses	140,824	24,489	6,734	172,047		172,047	143,881	315,928		21
22	Employee Benefits & Payroll Taxes			358,178	358,178		358,178	29,404	387,582		22
23	Inservice Training & Education			2,098	2,098		2,098	(99)	1,999		23
24	Travel and Seminar			9,739	9,739		9,739	(7,740)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			40,083	40,083		40,083	10,224	50,307		26
27	Other (specify):*			26,855	26,855		26,855	(26,000)	855		27
28	TOTAL General Administration	221,934	24,489	771,574	1,017,997	(50,370)	967,627	(23,361)	944,266		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,935,224	709,944	1,501,347	4,146,515	(384,026)	3,762,489	81,860	3,844,349		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-Dwight

#0037853

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			51,348	51,348		51,348	9,831	61,179			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,094	14,094		14,094	3,211	17,305			32
33	Real Estate Taxes			44,054	44,054		44,054		44,054			33
34	Rent-Facility & Grounds			198,458	198,458		198,458	9,978	208,436			34
35	Rent-Equipment & Vehicles			6,238	6,238		6,238	1,702	7,940			35
36	Other (specify):*											36
37	TOTAL Ownership			314,192	314,192		314,192	24,722	338,914			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					333,656	333,656		333,656			39
40	Barber and Beauty Shops			5,933	5,933		5,933		5,933			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					50,370	50,370		50,370			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			5,933	5,933	384,026	389,959		389,959			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,935,224	709,944	1,821,472	4,466,640		4,466,640	106,582	4,573,222			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-Dwight

0037853

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	(2,705)	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)	(727)	23		16
17	Non-Care Related Fees	(991)	20		17
18	Fines and Penalties				18
19	Entertainment	(16,947)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,916)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,000)	27		24
25	Fund Raising, Advertising and Promotional	(48,137)	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)	\$ (100,423)		\$	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)	207,005		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 207,005		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 106,582		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-Dwight

ID# 0037853

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		(727)	23
17		(991)	20
18			18
19			24
20		0	27
21			21
22		(4,916)	19
23			23
24		(26,000)	27
25		(48,137)	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	(80,771)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Dwight

0037853

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	5,064	0	0	0	0	0	0	0	0	5,064	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	19	0	0	0	0	0	0	0	0	19	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,782	0	0	0	0	0	0	0	0	1,782	5
6	Maintenance	0	0	12,682	0	0	0	0	0	0	0	0	12,682	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	19,547	0	0	0	0	0	0	0	0	19,547	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,067	0	0	0	0	0	0	0	0	2,067	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	81,224	0	0	0	0	0	0	0	0	0	81,224	10a
11	Activities	0	0	1,331	0	0	0	0	0	0	0	0	1,331	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,052	0	0	0	0	0	0	0	0	1,052	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	81,224	4,450	0	0	0	0	0	0	0	0	85,674	16
	C. General Administration													
17	Administrative	0	0	64,123	0	0	0	0	0	0	0	0	64,123	17
18	Directors Fees	0	0	6,830	0	0	0	0	0	0	0	0	6,830	18
19	Professional Services	(4,916)	(203,090)	6,959	0	0	0	0	0	0	0	0	(201,047)	19
20	Fees, Subscriptions & Promotions	(49,128)	0	6,191	0	0	0	0	0	0	0	0	(42,937)	20
21	Clerical & General Office Expenses	0	0	143,881	0	0	0	0	0	0	0	0	143,881	21
22	Employee Benefits & Payroll Taxes	0	0	29,404	0	0	0	0	0	0	0	0	29,404	22
23	Inservice Training & Education	(727)	0	628	0	0	0	0	0	0	0	0	(99)	23
24	Travel and Seminar	(16,947)	0	9,207	0	0	0	0	0	0	0	0	(7,740)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	10,224	0	0	0	0	0	0	0	0	10,224	26
27	Other (specify):*	(26,000)	0	0	0	0	0	0	0	0	0	0	(26,000)	27
28	TOTAL General Administration	(97,718)	(203,090)	277,447	0	0	0	0	0	0	0	0	(23,361)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(97,718)	(121,866)	301,444	0	0	0	0	0	0	0	0	81,860	29

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Dwight

0037853

Report Period Beginning:

01/01/08 Ending:

Summary B

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	0	0	9,831	0	0	0	0	0	0	0	9,831	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,705)	0	0	5,916	0	0	0	0	0	0	0	3,211	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	9,978	0	0	0	0	0	0	0	9,978	34
35	Rent-Equipment & Vehicles	0	0	0	1,702	0	0	0	0	0	0	0	1,702	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,705)	0	0	27,427	0	24,722	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)	(100,423)	(121,866)	301,444	27,427	0	106,582	45						

Facility Name & ID Number Heritage Manor-Dwight

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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		81,224	81,224
3	V						
4	V	19 Adjustment for Related Organization	203,090	Heritage Operations Group, LLC	0.00%		(203,090)
5	V						
6	V	34 Adjustment for Related Organization		Heritage Manor Real Estate, LLC	0.00%		
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC			
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC			
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC			
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC			
11	V						
12	V						
13	V						
14	Total		\$ 203,090			\$ 81,224	\$ * (121,866)

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

Facility Name & ID Number Heritage Manor-Dwight# 0037853Report 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%	\$ 5,064	\$ 5,064	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				19	19	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,782	1,782	19
20	V	6 Maintenance				12,682	12,682	20
21	V	7 Other				0		21
22	V	9 Medical Director				2,067	2,067	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,331	1,331	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				1,052	1,052	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				64,123	64,123	29
30	V	18 Directors Fees				6,830	6,830	30
31	V	19 Professional Services				6,959	6,959	31
32	V	20 Fees, Subscription, Promotions				6,191	6,191	32
33	V	21 Clerical & General Office Expenses				143,881	143,881	33
34	V	22 Employee Benefits & Payroll Taxes				29,404	29,404	34
35	V	23 Inservice Training & Education				628	628	35
36	V	24 Travel and Seminar				9,207	9,207	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				10,224	10,224	38
39	Total		\$			\$ 301,444	\$ * 301,444	39

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

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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				9,831	9,831	16	
17	V	31 Amortization of Pre-Op & Org				0		17	
18	V	32 Interest				5,916	5,916	18	
19	V	33 Real Estate Taxes				0		19	
20	V	34 Rent-Facility & Grounds				9,978	9,978	20	
21	V	35 Rent-Equipment & Vehicles				1,702	1,702	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		\$			\$ 27,427	\$ *	27,427	39

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

Facility Name & ID Number Heritage Manor-Dwight # 0037853 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					\$ 6,830	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	\$ 6,830		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-Dwight

0037853

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

1	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	92	\$ 5,064	1
2	2	Food Purchase	Beds	2,634	25	0	0	92	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	92	19	3
4	4	Laundry	Beds	2,634	25	0	0	92	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	92	1,782	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	92	12,682	6
7	7	Other	Beds	2,634	25	0	0	92	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	92	2,067	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	92	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	92	1,331	10
11	12	Social Service	Beds	2,634	25	0	0	92	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	92	1,052	12
13	14	Program Transportation	Beds	2,634	25	0	0	92	0	13
14	15	Other	Beds	2,634	25	0	0	92	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	92	64,123	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	92	6,830	16
17	19	Professional Services	Beds	2,634	25	199,226	0	92	6,959	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	92	6,191	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	92	143,881	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	92	29,404	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	92	628	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	92	9,207	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	92	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	92	10,224	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 301,444	25

Facility Name & ID Number Heritage Manor-Dwight

0037853

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	92	\$	92	\$	1
2	30	Depreciation	Beds	2,634	92	281,453	92	9,831	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	92		92		3
4	32	Interest	Beds	2,634	92	169,367	92	5,916	4
5	33	Real Estate Taxes	Beds	2,634	92		92		5
6	34	Rent-Facility & Grounds	Beds	2,634	92	285,687	92	9,978	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	92	48,715	92	1,702	7
8	36	Other	Beds	2,634	92		92		8
9	38	Medically Nec Transportation	Beds	2,634	92		92		9
10	39	Ancillary Service Centers	Beds	2,634	92		92		10
11	40	Barber and Beauty Shops	Beds	2,634	92		92		11
12	41	Coffee and Gift Shops	Beds	2,634	92		92		12
13	42	Other	Beds	2,634	92		92		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	\$	\$ 27,427	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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of Springfield		xx	Mortgage			\$	\$ 61,667	03/11	variable	\$ 326	1
2	Bank of Springfield		xx	Loan Fees								2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							13,768	6
7												7
8												8
9	TOTAL Facility Related						\$	\$ 61,667			\$ 14,094	9
	B. Non-Facility Related*											
10	Interest Income										(2,705)	10
11	Allocated Corporate										5,916	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 3,211	14
15	TOTALS (line 9+line14)						\$	\$ 61,667			\$ 17,305	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 49,690	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.)		\$ 45,729	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (3,961)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 48,015	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.		\$ 44,054	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	36,246	8
	2004	39,461	9
	2005	41,614	10
	2006	51,328	11
	2007	44,054	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:

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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Dwight COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0037853

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 2007 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 2007.

(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>050504483011</u>	_____	\$ <u>785.00</u>	\$ <u>785.00</u>
2. <u>050504483002</u>	_____	\$ <u>1,152.00</u>	\$ <u>1,152.00</u>
3. <u>050504483001</u>	_____	\$ <u>43,792.00</u>	\$ <u>43,792.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>45,729.00</u>	\$ <u>45,729.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Heritage Manor-Dwight

0037853 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,294 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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Heritage Manor-Dwight

0037853

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	92				\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	1992 Improvements				8,456						9
10	1993 Improvements				586,243						10
11	1994 Improvements				12,874						11
12	1995 Improvements				496						12
13	Water Heater			1996	7,350						13
14	Interior Rehab (see attached)			1997	118,804						14
15	Garbage Disposal			1997	983						15
16											16
17	Parking Lot			1998	2,717						17
18	Interior Rehab			1998	17,242						18
19											19
20	Alarm Repair/Replacement			1999	1,120						20
21	Air Conditioning Unit			1999	2,461						21
22	Shower Room Repair			1999	6,345						22
23											23
24	Fire Dampers			2000	1,290						24
25	Boiler			2000	1,540						25
26											26
27	Water Heater			2001	7,200						27
28	Window Replacements			2001	4,437						28
29	Flooring -- Kitchen			2001	604						29
30	Code Alert System			2001	933						30
31	Motor Reolacement--A/C			2001	1,398						31
32											32
33											33
34	C/O Allocation							9,831	9,831		34
35	Book Depreciation					32,847		32,847		800,170	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-Dwight

0037853

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	A/C compressor	2002	\$ 582	\$		\$	\$	\$	37
38	Boiler Tubing	2002	11,208						38
39	Backflow preventor	2002	2,803						39
40	Wallcoverings	2002	21,813						40
41	Compressor	2002	1,175						41
42	Rooftop A/C unit	2002	20,169						42
43	adustment	2002	(9,766)						43
44	Wallcoverings	2003	1,528						44
45	Rooftop A/C unit	2003							45
46	Exterior Doors	2003	3,121						46
47	30 Gallon Tank	2003	1,056						47
48	Compressor	2003	1,839						48
49	Walk in Freezer	2003	3,301						49
50	Disposal	2003	771						50
51									51
52	Fire Supression System	2004	1,523						52
53	Pump	2004	714						53
54	Boiler	2004	13,085						54
55	Water Softener	2004	1,467						55
56	Parking Lot Sealant	2004	2,800						56
57	Laundry drain	2004	2,350						57
58									58
59	Motor --Circulator	2005	1,674						59
60	Water Heater	2005	10,113						60
61	Kitchen Door	2005	240						61
62	A/C compressor	2005	175						62
63	Generator Panel	2005	833						63
64	Closet Rehab	2005	1,137						64
65	Exterior Lights	2005	127						65
66	A/C compressor	2005	4,597						66
67	Kitchen Water Heater	2005	1,059						67
68	Sidewalks	2005	7,450						68
69	Boiler Repair	2005	1,967						69
70	TOTAL (lines 4 thru 69)		\$ 893,404	\$ 32,847		\$ 42,678	\$ 9,831	\$ 800,170	70

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

Facility Name & ID Number Heritage Manor-Dwight

0037853

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		\$ 893,404	\$ 32,847		\$ 42,678	\$ 9,831	\$ 800,170	1
2	Inline exhaust	2006	2,465						2
3	A/C compressor	2006	8,093						3
4	Exhaust fan	2006	2,435						4
5	Roof	2006	97,870						5
6	Dayroom -- paint	2006							6
7	Sewer	2006	2,260						7
8									8
9	Dayroom -- paint	2007	10,633						9
10	In-sink Erator	2007	895						10
11	Rooftop A/C	2007	12,269						11
12	Window	2007	583						12
13	Water Softener	2007	17,709						13
14	Water Heater	2007	11,668						14
15	Exterior Panting	2007	14,215						15
16	Water Heater	2007	12,140						16
17	adjustments	2007	(3,034)						17
18	Boiler	2008	6,030						18
19	Kitchen/Restroom Upgrade	2008	3,989						19
20	HVAC Unit	2008	13,845						20
21	Resident Room/Corridor Painting	2008	4,275						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)		\$ 1,111,744	\$ 32,847		\$ 42,678	\$ 9,831	\$ 800,170	34

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

Facility Name & ID Number Heritage Manor-Dwight

0037853

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 12B, Carried Forward	\$ 1,111,744	\$ 32,847		\$ 42,678	\$ 9,831	\$ 800,170		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)	\$ 1,111,744	\$ 32,847		\$ 42,678	\$ 9,831	\$ 800,170		34

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

Facility Name & ID Number Heritage Manor-Dwight

0037853

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 12C, Carried Forward	\$ 1,111,744	\$ 32,847		\$ 42,678	\$ 9,831	\$ 800,170		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)	\$ 1,111,744	\$ 32,847		\$ 42,678	\$ 9,831	\$ 800,170		34

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

Facility Name & ID Number Heritage Manor-Dwight # 0037853 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	\$ 398,408	\$ 18,501	\$ 18,501	\$		\$ 353,313	71
72	Current Year Purchases	37,201						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 435,609	\$ 18,501	\$ 18,501	\$		\$ 353,313	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		2009Turtletop Van	2008	\$ 62,091	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 62,091	\$	\$	\$		\$	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)	\$ 1,609,444	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 51,348	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 61,179	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,831	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,153,483	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: Dwight Continental Manor

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:		92	1992	\$ 198,458	20	0	3
4	Additions							4
5								5
6								6
7	TOTAL		92		\$ 198,458			7

10. Effective dates of current rental agreement:

Beginning 3/1/92

Ending 3/1/12

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	<u>/2009</u>	\$ <u>198,458</u>
13.	<u>/2010</u>	\$ <u>198,458</u>
14.	<u>/2011</u>	\$ <u>198,458</u>

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: \$ 6,238 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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		739		739
3	Classroom Wages (a)				
4	Clinical Wages (b)		1,299		1,299
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,038	\$	\$ 2,038
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,038		

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	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	\$		\$ 189,918	\$		\$ 189,918	1
2	Licensed Speech and Language Development Therapist		hrs			26,422			26,422	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			141,834	0		141,834	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				302,503		302,503	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					31,153			31,153	13
14	TOTAL			\$		\$ 389,327	\$ 302,503		\$ 691,830	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-Dwight# 0037853Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 31,696	\$	1
2	Cash-Patient Deposits	7,293		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	888,241		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,472		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(741,727)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 211,975	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	1,120,238		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	497,700		16
17	Accumulated Depreciation (book methods)	(1,153,483)		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)	\$ 464,455	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 676,430	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 250,612	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,293		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	225,641		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,775		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,015		32
33	Accrued Interest Payable	214		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>IPA Tax</u>	12,696		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 547,246	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	61,667		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)	\$ 61,667	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 608,913	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 67,517	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 676,430	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (266,893)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (266,893)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	334,410	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)	\$ 334,410	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)	\$ 67,517	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Dwight

0037853

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	\$ 4,688,881	1
2	Discounts and Allowances for all Levels	(1,782,341)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,906,540	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,328,935	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,328,935	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	2,504	12
13	Barber and Beauty Care	8,416	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	551,950	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 562,870	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,705	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,705	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)	\$ 4,801,050	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	850,236	31
32	Health Care	2,278,282	32
33	General Administration	1,017,997	33
B. Capital Expense			
34	Ownership	314,192	34
C. Ancillary Expense			
35	Special Cost Centers	5,933	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)*	\$ 4,466,640	40
41	Income before Income Taxes (line 30 minus line 40)**	334,410	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 334,410	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-Dwight

0037853

Report Period Beginning: 01/01/08

Ending:

12/31/08

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	1,532	2,080	\$ 45,470	\$ 21.86	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	6,095	6,628	167,969	25.34	3
4	Licensed Practical Nurses	12,182	12,893	281,440	21.83	4
5	CNAs & Orderlies	44,258	46,649	607,361	13.02	5
6	CNA Trainees	100	100	1,299	12.99	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,710	4,081	63,804	15.63	8
9	Activity Director					9
10	Activity Assistants	4,989	5,445	64,810	11.90	10
11	Social Service Workers	3,901	4,357	60,122	13.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,691	20,041	207,586	10.36	15
16	Dishwashers					16
17	Maintenance Workers	4,243	4,447	61,089	13.74	17
18	Housekeepers	9,220	9,925	101,285	10.21	18
19	Laundry	6,412	6,630	51,055	7.70	19
20	Administrator	1,900	2,080	81,110	39.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,998	8,851	140,824	15.91	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)	125,231	134,207	\$ 1,935,224 *	\$ 14.42	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		9,600		36
37	Medical Records Consultant		2,440		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,760		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,110		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,910		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	196	\$ 7,852		50
51	Licensed Practical Nurses	95	3,309		51
52	Certified Nurse Assistants/Aides	4,656	116,395		52
53	TOTAL (lines 50 - 52)	4,947	\$ 127,556		53

Facility Name & ID Number Heritage Manor-Dwight

0037853

Report Period Beginning: 01/01/08

Ending: 12/31/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Randy Provence	admin	0	\$ 81,110	Workers' Compensation Insurance	\$ 38,523	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	21,272	Advertising: Employee Recruitment	10,200	
				FICA Taxes	148,045	Health Care Worker Background Check		
				Employee Health Insurance	123,482	(Indicate # of checks performed)	1,340	
				Employee Meals		Patient Background Checks	6,191	
				Illinois Municipal Retirement Fund (IMRF)*			13,600	
					0		11,825	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 81,110		26,856	Dues & Subscriptions	6,373	
(List each licensed administrator separately.)					29,404	License & Fees	3,461	
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 387,582	
(Attach a copy of any management service agreement)							TOTAL (agree to Sch. V, line 20, col. 8)	
							\$ 26,574	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Heritage Operations Group	Mgt Fee		\$ 203,090			\$	Out-of-State Travel	\$
			0					
			0					
			0				In-State Travel	
								5,050
								704
							Seminar Expense	3,985
								(16,947)
			0				Central Office	9,207
legal to zero			4,916					
			0				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 208,006	TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							\$ 1,999	

* Attach copy of IMRF notifications

**See instructions.

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 Gibson City 38315 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,370
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. \$ 2,032
- (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.

Code	Description	Unit	Rate	Amount
1000
1001
1002
1003
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1005
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1007
1008
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1013
1014
1015
1016
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