

Facility Name & ID Number Heritage Manor-Chillicothe

0048868 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>21,873</u>	<u>10,156</u>	<u>3,775</u>	<u>35,804</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>21,873</u>	<u>10,156</u>	<u>3,775</u>	<u>35,804</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.18%

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 07/2007

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided 3,775

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-Chillicothe # 0048868 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	229,237	18,896		248,133		248,133	4,289	252,422		1
2	Food Purchase		214,570		214,570		214,570	1	214,571		2
3	Housekeeping	102,629	13,137		115,766		115,766		115,766		3
4	Laundry	44,186	13,620		57,806		57,806		57,806		4
5	Heat and Other Utilities			110,490	110,490		110,490	2,197	112,687		5
6	Maintenance	62,878	70,089	57,789	190,756		190,756	21,901	212,657		6
7	Other (specify):*										7
8	TOTAL General Services	438,930	330,312	168,279	937,521		937,521	28,388	965,909		8
	B. Health Care and Programs										
9	Medical Director			12,148	12,148		12,148	2,132	14,280		9
10	Nursing and Medical Records	1,870,996	186,473	14,507	2,071,976		2,071,976		2,071,976		10
10a	Therapy		322,239	652,865	975,104	(351,846)	623,258	256,432	879,690		10a
11	Activities	89,266	5,925		95,191		95,191	955	96,146		11
12	Social Services	23,555	14	3,296	26,865		26,865		26,865		12
13	CNA Training	1,659	280		1,939		1,939	1,560	3,499		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,985,476	514,931	682,816	3,183,223	(351,846)	2,831,377	261,079	3,092,456		16
	C. General Administration										
17	Administrative	85,987			85,987		85,987		85,987		17
18	Directors Fees										18
19	Professional Services			272,034	272,034		272,034	(258,582)	13,452		19
20	Dues, Fees, Subscriptions & Promotions			161,483	161,483	(60,225)	101,258	(68,393)	32,865		20
21	Clerical & General Office Expenses	186,012	33,645	15,844	235,501		235,501	270,193	505,694		21
22	Employee Benefits & Payroll Taxes			574,325	574,325		574,325	35,477	609,802		22
23	Inservice Training & Education			4,262	4,262		4,262	1,111	5,373		23
24	Travel and Seminar			19,102	19,102		19,102	9,978	29,080		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			55,030	55,030		55,030	11,854	66,884		26
27	Other (specify):*			20,840	20,840		20,840	(20,840)			27
28	TOTAL General Administration	271,999	33,645	1,122,920	1,428,564	(60,225)	1,368,339	(19,202)	1,349,137		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,696,405	878,888	1,974,015	5,549,308	(412,071)	5,137,237	270,265	5,407,502		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:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation						217,912	217,912				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,923	12,923		12,923	229,587	242,510			32
33	Real Estate Taxes							79,983	79,983			33
34	Rent-Facility & Grounds			481,800	481,800		481,800	(474,975)	6,825			34
35	Rent-Equipment & Vehicles			9,404	9,404		9,404	1,812	11,216			35
36	Other (specify):*											36
37	TOTAL Ownership			504,127	504,127		504,127	54,319	558,446			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					351,846	351,846		351,846			39
40	Barber and Beauty Shops			6,286	6,286		6,286		6,286			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			6,286	6,286	412,071	418,357		418,357			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,696,405	878,888	2,484,428	6,059,721		6,059,721	324,584	6,384,305			45

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

Heritage Manor-Chillicothe

ID# 0048868

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5		0	35 5
6		0	34 6
7			7
8			8
9		0	30 9
10			32 10
11			11
12			12
13		0	2 13
14			32 14
15		0	33 15
16			24 16
17		(1,305)	20 17
18			18
19			24 19
20		(2,840)	27 20
21			21
22		(11,746)	19 22
23			23
24		(18,000)	27 24
25		(75,843)	20 25
26			26
27			27
28			28
29		0	33 29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(109,734)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Chillicothe# 0048868

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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	4,289	0	0	0	0	0	0	0	0	4,289	1
2	Food Purchase	0	0	1	0	0	0	0	0	0	0	0	1	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,197	0	0	0	0	0	0	0	0	2,197	5
6	Maintenance	0	0	21,901	0	0	0	0	0	0	0	0	21,901	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	28,388	0	28,388	8							
	B. Health Care and Programs													
9	Medical Director	0	0	2,132	0	0	0	0	0	0	0	0	2,132	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	256,432	0	0	0	0	0	0	0	0	0	256,432	10a
11	Activities	0	0	955	0	0	0	0	0	0	0	0	955	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,560	0	0	0	0	0	0	0	0	1,560	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	256,432	4,647	0	261,079	16							
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,746)	(260,288)	13,452	0	0	0	0	0	0	0	0	(258,582)	19
20	Fees, Subscriptions & Promotions	(77,148)	0	8,755	0	0	0	0	0	0	0	0	(68,393)	20
21	Clerical & General Office Expenses	0	0	270,193	0	0	0	0	0	0	0	0	270,193	21
22	Employee Benefits & Payroll Taxes	0	0	35,477	0	0	0	0	0	0	0	0	35,477	22
23	Inservice Training & Education	0	0	1,111	0	0	0	0	0	0	0	0	1,111	23
24	Travel and Seminar	0	0	9,978	0	0	0	0	0	0	0	0	9,978	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	11,854	0	0	0	0	0	0	0	0	11,854	26
27	Other (specify):*	(20,840)	0	0	0	0	0	0	0	0	0	0	(20,840)	27
28	TOTAL General Administration	(109,734)	(260,288)	350,820	0	(19,202)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(109,734)	(3,856)	383,855	0	270,265	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Chillicothe# 0048868

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	207,480	0	10,432	0	0	0	0	0	0	0	217,912	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,111)	234,333	0	365	0	0	0	0	0	0	0	229,587	32
33	Real Estate Taxes	0	79,983	0	0	0	0	0	0	0	0	0	79,983	33
34	Rent-Facility & Grounds	0	(481,800)	0	6,825	0	0	0	0	0	0	0	(474,975)	34
35	Rent-Equipment & Vehicles	0	0	0	1,812	0	0	0	0	0	0	0	1,812	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,111)	39,996	0	19,434	0	54,319	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(114,845)	36,140	383,855	19,434	0	0	0	0	0	0	0	324,584	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
Heritage Enterprises, Inc.	100%	See Attached				

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

YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$		1
2	V	10a Adjustment for Related Organization		GreenTree Pharmacy	0.00%	256,432	256,432	2
3	V							3
4	V	19 Adjustment for Related Organization	260,288	Heritage Operations Group, LLC	0.00%		(260,288)	4
5	V							5
6	V	34 Adjustment for Related Organization	481,800	Heritage Manor Real Estate, LLC	0.00%		(481,800)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		79,983	79,983	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		228,889	228,889	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		207,480	207,480	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,444	5,444	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 742,088			\$ 778,228	\$ * 36,140	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	4,289	15	
16	V	2 Food Purchase						1	16	
17	V	3 Housekeeping						0	17	
18	V	4 Laundry						0	18	
19	V	5 Heat & Other Utilities						2,197	19	
20	V	6 Maintenance						21,901	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						2,132	22	
23	V	10 Nursing & Medical Records						0	23	
24	V	11 Activities						955	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,560	26	
27	V	14 Program Transportation						0	27	
28	V	15 Other						0	28	
29	V	17 Administrative						0	29	
30	V	18 Directors Fees						0	30	
31	V	19 Professional Services						13,452	31	
32	V	20 Fees, Subscription, Promotions						8,755	32	
33	V	21 Clerical & General Office Expenses						270,193	33	
34	V	22 Employee Benefits & Payroll Taxes						35,477	34	
35	V	23 Inservice Training & Education						1,111	35	
36	V	24 Travel and Seminar						9,978	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						11,854	38	
39	Total		\$			\$	0	\$ *	383,855	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$	Heritage Enterprises, Inc.	0.00%	\$	0	15
16	V	30 Depreciation					10,432	16
17	V	31 Amortization of Pre-Op & Org					0	17
18	V	32 Interest					365	18
19	V	33 Real Estate Taxes					0	19
20	V	34 Rent-Facility & Grounds					6,825	20
21	V	35 Rent-Equipment & Vehicles					1,812	21
22	V	36 Other					0	22
23	V	38 Medically Nec Transportation					0	23
24	V	39 Ancillary Service Centers					0	24
25	V	40 Barber and Beauty Shops					0	25
26	V	41 Coffee and Gift Shops					0	26
27	V	42 Other					0	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ * 19,434 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:

01/01/2009

Ending:

12/31/2009

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					\$ 0	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	\$		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:

01/01/2009

Ending: 2/31/2009

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	\$ 102,708	\$ 102,349	110	\$ 4,289	1
2	2	Food Purchase	Beds	2,634	25	29	0	110	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	110	0	3
4	4	Laundry	Beds	2,634	25	0	0	110	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	110	2,197	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	110	21,901	6
7	7	Other	Beds	2,634	25	0	0	110	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	110	2,132	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	110	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	110	955	10
11	12	Social Service	Beds	2,634	25	0	0	110	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	110	1,560	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	0	0	110	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	110	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	110	13,452	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	110	8,755	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	110	270,193	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	110	35,477	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	110	1,111	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	110	9,978	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	283,859	0	110	11,854	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 383,855	25

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

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 _____

Street Address _____

City / State / Zip Code _____

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	27	Other	Beds	2,634	25	\$	110	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	110	10,432	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		110		3
4	32	Interest	Beds	2,634	25	8,747	110	365	4
5	33	Real Estate Taxes	Beds	2,634	25		110		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	110	6,825	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	110	1,812	7
8	36	Other	Beds	2,634	25		110		8
9	38	Medically Nec Transportation	Beds	2,634	25		110		9
10	39	Ancillary Service Centers	Beds	2,634	25		110		10
11	40	Barber and Beauty Shops	Beds	2,634	25		110		11
12	41	Coffee and Gift Shops	Beds	2,634	25		110		12
13	42	Other	Beds	2,634	25		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					\$ 465,371	\$	\$ 19,434	25

Facility Name & ID Number

Heritage Manor-Chillicothe

0048868

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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		8	9	10				
						Amount of Note						Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
						Original	Balance							
Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note									
YES	NO													
A. Directly Facility Related														
Long-Term														
1	Busey Bank		xx	Mortgage			\$	\$ 3,589,356	03/11	variable	\$ 226,387	1		
2	Busey Bank		xx	Loan Fees							5,444	2		
3	Alpha Bank							22,130			2,502	3		
4												4		
5												5		
Working Capital														
6	Bank of America		xx	Accounts Receivable							12,923	6		
7												7		
8												8		
9	TOTAL Facility Related						\$	\$ 3,611,486			\$ 247,256	9		
B. Non-Facility Related*														
10	Interest Income										(5,111)	10		
11	Allocated Corporate										365	11		
12												12		
13												13		
14	TOTAL Non-Facility Related						\$	\$			\$ (4,746)	14		
15	TOTALS (line 9+line14)						\$	\$ 3,611,486			\$ 242,510	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

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and			
1. Real Estate Tax accrual used on 2008 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.)		\$	79,983		2
3. Under or (over) accrual (line 2 minus line 1).		\$	79,983		3
4. Real Estate Tax accrual used for 2009 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.		\$	79,983		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2004	36,943	8	FOR BHF USE ONLY	
	2005	42,119	9	13	FROM R. E. TAX STATEMENT FOR 2008 \$ 13
	2006	39,581	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2007	75,324	11	15	LESS REFUND FROM LINE 6 \$ 15
	2008	79,983	12	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.

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,331 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <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:

01/01/2009

Ending:

12/31/2009

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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	110			\$ 3,301,403	\$		\$	\$	\$
5									
6									
7									
8									
	Improvement Type**								
9	Awning		1998	2,334					
10	Heritage Sign		1998	1,860					
11	Chiller Replacement		1998	54,444					
12									
13	Interior Remodel--Materials		1999	154,576					
14			1999						
15	Interior Remodel--Professional Fees		1999	24,247					
16									
17	Water Heater controls		2000	1,347					
18	Water Heater		2000	57,254					
19	Door Locks		2000	1,997					
20	Heat / Cool Fan		2000	1,598					
21	Fire Alarm System		2000	4,400					
22	Alzheimer Unit -- Professional Fees		2000	25,115					
23	Interior Remodel--Materials (see attached)		2000	93,951					
24	Interior Remodel--Labor (see attached)		2000	23,130					
25	Interior Remodel--Professional Fees (see attached)		2000	5,762					
26									
27	Water Softener		2001	4,246					
28	Boiler		2001	29,350					
29	Door Holders		2001	654					
30	Alzheimer Unit -- Professional Fees		2001	4,660					
31									
32									
33									
34	C/O Allocation						10,432	10,432	
35	Book Depreciation				166,445		166,445		1,448,629
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:

01/01/2009 Ending: 12/31/2009

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	
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 Storage 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 Dining 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	\$ 166,445		\$ 176,877	\$ 10,432	\$ 1,448,629	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:

01/01/2009 Ending: 12/31/2009

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	\$ 166,445		\$ 176,877	\$ 10,432	\$ 1,448,629	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	23,281						11
12	Boiler	2007							12
13	Fire Alarm	2007							13
14	Generator	2007							14
15	Code Alert	2007	4,622						15
16	Fence	2007	3,089						16
17	Landscapping	2007							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							21
22									22
23	East Wing Remodel-- paint, floors	2008	61,290						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)		\$ 4,334,335	\$ 166,445		\$ 176,877	\$ 10,432	\$ 1,448,629	34

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

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		\$ 4,334,335	\$ 166,445		\$ 176,877	\$ 10,432	\$ 1,448,629	1
2								2
3	2009	64,129						3
4								4
5	2009	6,180						5
6	2009	26,052						6
7	2009	226,889						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		\$ 4,657,585	\$ 166,445		\$ 176,877	\$ 10,432	\$ 1,448,629	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:

01/01/2009

Ending:

12/31/2009

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	\$ 571,359	\$ 41,035	\$ 41,035	\$		\$ 471,711	71
72	Current Year Purchases	99,261						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 670,620	\$ 41,035	\$ 41,035	\$		\$ 471,711	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)	\$ 5,457,205	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 207,480	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 217,912	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,432	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,920,340	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 9,404 Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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		280		280
3	Classroom Wages (a)				
4	Clinical Wages (b)		1,659		1,659
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,939	\$	\$ 1,939
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,939		

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	\$		\$ 213,356	\$		\$ 213,356	1
2	Licensed Speech and Language Development Therapist		hrs			117,236			117,236	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			291,538	1,128		292,666	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				321,111		321,111	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					30,735			30,735	13
14	TOTAL			\$		\$ 652,865	\$ 322,239		\$ 975,104	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-Chillicothe# 0048868Report Period Beginning: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 32,627	\$	1
2	Cash-Patient Deposits	24,352		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	687,302		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,168		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(178,500)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 570,949	\$	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)	\$ 570,949	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 161,515	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,352		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	258,691		30
31	Accrued Taxes Payable (excluding real estate taxes)	94		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 444,652	\$	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)	\$ 444,652	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 126,297	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 570,949	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (93,493)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (93,493)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	219,790	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)	\$ 219,790	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)	\$ 126,297	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Chillicothe# 0048868Report Period Beginning: 01/01/2009Ending: 12/31/2009

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	\$ 6,038,416	1
2	Discounts and Allowances for all Levels	(2,451,130)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,587,286	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,127,435	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,127,435	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	171	12
13	Barber and Beauty Care	6,489	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	550,412	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,607	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 559,679	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	5,111	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,111	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)	\$ 6,279,511	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	937,521	31
32	Health Care	3,183,223	32
33	General Administration	1,428,564	33
B. Capital Expense			
34	Ownership	504,127	34
C. Ancillary Expense			
35	Special Cost Centers	6,286	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)*	\$ 6,059,721	40
41	Income before Income Taxes (line 30 minus line 40)**	219,790	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 219,790	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**

0048868

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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	1,901	2,080	\$ 63,907	\$ 30.72	1
2	Assistant Director of Nursing	2,061	2,235	57,510	25.73	2
3	Registered Nurses	7,812	8,184	212,141	25.92	3
4	Licensed Practical Nurses	18,921	19,912	495,831	24.90	4
5	CNAs & Orderlies	63,713	68,561	964,567	14.07	5
6	CNA Trainees	160	160	1,659	10.37	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,567	4,787	77,040	16.09	8
9	Activity Director					9
10	Activity Assistants	6,188	6,846	89,266	13.04	10
11	Social Service Workers	1,669	2,064	23,555	11.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,213	21,600	229,237	10.61	15
16	Dishwashers					16
17	Maintenance Workers	3,513	3,833	62,878	16.40	17
18	Housekeepers	9,699	8,202	102,629	12.51	18
19	Laundry	4,555	4,795	44,186	9.22	19
20	Administrator	1,900	2,080	85,987	41.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,450	10,490	186,012	17.73	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)	156,322	165,829	\$ 2,696,405 *	\$ 16.26	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	12,148		36
37	Medical Records Consultant	1,840		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	3,296		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 20,584		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 4	171	50
51	Licensed Practical Nurses	263	9,196	51
52	Certified Nurse Assistants/Aides	0	0	52
53	TOTAL (lines 50 - 52)	267	\$ 9,367	53

Facility Name & ID Number Heritage Manor-Chillicothe# 0048868Report Period Beginning: 01/01/2009 Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7yrs
- (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? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 1,331
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.