

Facility Name & ID Number Heritage Manor-Litchfield

0048900 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	102	Skilled (SNF)	102	37,230	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	102	TOTALS	102	37,230	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	15,102	8,964	2,713	26,779	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,102	8,964	2,713	26,779	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.93%

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 2,713

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-Litchfield # 0048900 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	162,623	10,876		173,499		173,499	3,977	177,476		1
2	Food Purchase		185,188		185,188		185,188	1	185,189		2
3	Housekeeping	101,841	19,102		120,943		120,943		120,943		3
4	Laundry	47,300	11,532		58,832		58,832		58,832		4
5	Heat and Other Utilities			120,214	120,214		120,214	2,037	122,251		5
6	Maintenance	65,274	35,663	37,542	138,479		138,479	20,308	158,787		6
7	Other (specify):*										7
8	TOTAL General Services	377,038	262,361	157,756	797,155		797,155	26,323	823,478		8
	B. Health Care and Programs										
9	Medical Director			16,173	16,173		16,173	1,977	18,150		9
10	Nursing and Medical Records	1,330,962	114,117	4,147	1,449,226		1,449,226		1,449,226		10
10a	Therapy		149,102	357,433	506,535	(169,280)	337,255	124,952	462,207		10a
11	Activities	50,665	1,767		52,432		52,432	885	53,317		11
12	Social Services	40,958		1,172	42,130		42,130		42,130		12
13	CNA Training		200		200		200	1,447	1,647		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,422,585	265,186	378,925	2,066,696	(169,280)	1,897,416	129,261	2,026,677		16
	C. General Administration										
17	Administrative	80,583			80,583		80,583		80,583		17
18	Directors Fees										18
19	Professional Services			190,619	190,619		190,619	(178,145)	12,474		19
20	Dues, Fees, Subscriptions & Promotions			78,048	78,048	(55,845)	22,203	(1,236)	20,967		20
21	Clerical & General Office Expenses	120,218	25,630	9,557	155,405		155,405	250,543	405,948		21
22	Employee Benefits & Payroll Taxes			400,729	400,729		400,729	32,897	433,626		22
23	Inservice Training & Education			3,933	3,933		3,933	1,030	4,963		23
24	Travel and Seminar			6,559	6,559		6,559	9,252	15,811		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,897	47,897		47,897	10,992	58,889		26
27	Other (specify):*			200	200		200	(200)			27
28	TOTAL General Administration	200,801	25,630	737,542	963,973	(55,845)	908,128	125,133	1,033,261		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,000,424	553,177	1,274,223	3,827,824	(225,125)	3,602,699	280,717	3,883,416		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							192,828	192,828			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,990	11,990		11,990	88,435	100,425			32
33	Real Estate Taxes							73,365	73,365			33
34	Rent-Facility & Grounds			446,760	446,760		446,760	(440,431)	6,329			34
35	Rent-Equipment & Vehicles			9,951	9,951		9,951	1,681	11,632			35
36	Other (specify):*											36
37	TOTAL Ownership			468,701	468,701		468,701	(84,122)	384,579			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					169,280	169,280		169,280			39
40	Barber and Beauty Shops			14,454	14,454		14,454		14,454			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					55,845	55,845		55,845			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			14,454	14,454	225,125	239,579		239,579			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,000,424	553,177	1,757,378	4,310,979		4,310,979	196,595	4,507,574			45

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

Heritage Manor-Litchfield

ID# 0048900

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		(835)	20	17
18				18
19			24	19
20		(200)	27	20
21				21
22		(4,565)	19	22
23				23
24		0	27	24
25		(8,520)	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	(14,120)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Litchfield# 0048900

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	3,977	0	0	0	0	0	0	0	0	3,977	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	2,037	0	0	0	0	0	0	0	0	2,037	5
6	Maintenance	0	0	20,308	0	0	0	0	0	0	0	0	20,308	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	26,323	0	26,323	8							
	B. Health Care and Programs													
9	Medical Director	0	0	1,977	0	0	0	0	0	0	0	0	1,977	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	124,952	0	0	0	0	0	0	0	0	0	124,952	10a
11	Activities	0	0	885	0	0	0	0	0	0	0	0	885	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,447	0	0	0	0	0	0	0	0	1,447	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	124,952	4,309	0	129,261	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	(4,565)	(186,054)	12,474	0	0	0	0	0	0	0	0	(178,145)	19
20	Fees, Subscriptions & Promotions	(9,355)	0	8,119	0	0	0	0	0	0	0	0	(1,236)	20
21	Clerical & General Office Expenses	0	0	250,543	0	0	0	0	0	0	0	0	250,543	21
22	Employee Benefits & Payroll Taxes	0	0	32,897	0	0	0	0	0	0	0	0	32,897	22
23	Inservice Training & Education	0	0	1,030	0	0	0	0	0	0	0	0	1,030	23
24	Travel and Seminar	0	0	9,252	0	0	0	0	0	0	0	0	9,252	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	10,992	0	0	0	0	0	0	0	0	10,992	26
27	Other (specify):*	(200)	0	0	0	0	0	0	0	0	0	0	(200)	27
28	TOTAL General Administration	(14,120)	(186,054)	325,307	0	125,133	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,120)	(61,102)	355,939	0	280,717	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Litchfield# 0048900

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	183,155	0	9,673	0	0	0	0	0	0	0	192,828	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,283)	91,379	0	339	0	0	0	0	0	0	0	88,435	32
33	Real Estate Taxes	0	73,365	0	0	0	0	0	0	0	0	0	73,365	33
34	Rent-Facility & Grounds	0	(446,760)	0	6,329	0	0	0	0	0	0	0	(440,431)	34
35	Rent-Equipment & Vehicles	0	0	0	1,681	0	0	0	0	0	0	0	1,681	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,283)	(98,861)	0	18,022	0	(84,122)	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)	(17,403)	(159,963)	355,939	18,022	0	196,595	45						

Facility Name & ID Number

Heritage Manor-Litchfield

0048900

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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%	124,952	124,952	2
3	V							3
4	V	19 Adjustment for Related Organization	186,054	Heritage Operations Group, LLC	0.00%		(186,054)	4
5	V							5
6	V	34 Adjustment for Related Organization	446,760	Heritage Manor Real Estate, LLC	0.00%		(446,760)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		73,365	73,365	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		85,695	85,695	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		183,155	183,155	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,684	5,684	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 632,814			\$ 472,851	\$ * (159,963)	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%	\$	\$	3,977	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						2,037	19	
20	V	6 Maintenance						20,308	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						1,977	22	
23	V	10 Nursing & Medical Records						0	23	
24	V	11 Activities						885	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,447	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						12,474	31	
32	V	20 Fees, Subscription, Promotions						8,119	32	
33	V	21 Clerical & General Office Expenses						250,543	33	
34	V	22 Employee Benefits & Payroll Taxes						32,897	34	
35	V	23 Inservice Training & Education						1,030	35	
36	V	24 Travel and Seminar						9,252	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						10,992	38	
39	Total		\$			\$	0	\$ *	355,939	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						9,673	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						339	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						6,329	20	
21	V	35 Rent-Equipment & Vehicles						1,681	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	\$ *	18,022	39

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

Facility Name & ID Number Heritage Manor-Litchfield # 0048900 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-Litchfield# 0048900

Report Period Beginning:

01/01/2009Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Heritage Operations Group

Street Address

box 3188

City / State / Zip Code

Bloomington, IL 61701

Phone Number

()

Fax Number

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 102,708	\$ 102,349	102	\$ 3,977	1
2	2	Food Purchase	Beds	2,634	25	29	0	102	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	102	0	3
4	4	Laundry	Beds	2,634	25	0	0	102	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	102	2,037	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	102	20,308	6
7	7	Other	Beds	2,634	25	0	0	102	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	102	1,977	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	102	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	102	885	10
11	12	Social Service	Beds	2,634	25	0	0	102	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	102	1,447	12
13	14	Program Transportation	Beds	2,634	25	0	0	102	0	13
14	15	Other	Beds	2,634	25	0	0	102	0	14
15	17	Administrative	Beds	2,634	25	0	0	102	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	102	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	102	12,474	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	102	8,119	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	102	250,543	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	102	32,897	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	102	1,030	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	102	9,252	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	102	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	102	10,992	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 355,939	25

Facility Name & ID Number Heritage Manor-Litchfield

0048900

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	\$	102	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	102	9,673	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		102		3
4	32	Interest	Beds	2,634	25	8,747	102	339	4
5	33	Real Estate Taxes	Beds	2,634	25		102		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	102	6,329	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	102	1,681	7
8	36	Other	Beds	2,634	25		102		8
9	38	Medically Nec Transportation	Beds	2,634	25		102		9
10	39	Ancillary Service Centers	Beds	2,634	25		102		10
11	40	Barber and Beauty Shops	Beds	2,634	25		102		11
12	41	Coffee and Gift Shops	Beds	2,634	25		102		12
13	42	Other	Beds	2,634	25		102		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	\$	\$ 18,022	25

Facility Name & ID Number

Heritage Manor-Litchfield

0048900

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	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Busey Bank		xx	Mortgage			\$	\$ 1,719,911	03/11	variable	\$ 83,153	1							
2	Busey Bank		xx	Loan Fees							5,684	2							
3	Bank of Springfield		xx	Van				50,416			2,542	3							
4												4							
5												5							
Working Capital																			
6	Bank of America		xx	Accounts Receivable							11,990	6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$ 1,770,327			\$ 103,369	9							
B. Non-Facility Related*																			
10	Interest Income										(3,283)	10							
11	Allocated Corporate										339	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (2,944)	14							
15	TOTALS (line 9+line14)						\$	\$ 1,770,327			\$ 100,425	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.)

Facility Name & ID Number Heritage Manor-Litchfield

0048900

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,802 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>6,816</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ <u>6,816</u>	<u>3</u>

Facility Name & ID Number Heritage Manor-Litchfield

0048900

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	102				\$ 3,364,350	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Symmons Mixing Valve		1997	2,000						9
10		Boiler		1997	5,612						10
11		Dinning Room Roof Repair		1997	2,755						11
12		Roof Repair		1997	3,280						12
13											13
14		Laundry Room Central Air		1996	3,019						14
15		Heritage Manor Sign		1996	2,173						15
16											16
17		Roof		1998	60,674						17
18		Booster Heater		1998	1,717						18
19		Heat/Cool Units		1998	3,433						19
20		Garbage Disposal		1998	730						20
21											21
22											22
23											23
24											24
25											25
26				1999	920						26
27		Recirculating Pump		1999	2,046						27
28		Plumbing repairs/Replacement		1999	10,045						28
29		Carpet		1999	2,335						29
30		Interior Painting--Materials and Labor									30
31		Water Heater									31
32											32
33											33
34		C/O Allocation						9,673	9,673		34
35		Book Depreciation				137,531		137,531		1,365,630	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-Litchfield# 0048900

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	
37	Rooftop A/C Unit	2000	\$ 3,348	\$		\$	\$	\$	37
38	Blacktop Walkway	2000	2,250						38
39	Gazebo	2000	7,675						39
40									40
41	A/C Unit	2001	3,879						41
42	Gazebo	2001	981						42
43									43
44	A/C Unit	2002	1,453						44
45	A/C Unit	2002	3,120						45
46	Disposal	2002	794						46
47	Boiler	2002	1,453						47
48									48
49	A/C Unit	2003	3,458						49
50	A/C Unit	2003	833						50
51	A/C Unit	2003	2,440						51
52	A/C Unit	2003	4,542						52
53	Food Processor	2003	1,227						53
54	Ansul System	2003	1,271						54
55									55
56	Heat/Cool Units	2004	7,437						56
57	Resurface Parking Lot	2004	30,570						57
58	Roof Repair	2004	6,110						58
59	Rooftop A/C Unit	2004	3,479						59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,551,409	\$ 137,531		\$ 147,204	\$ 9,673	\$ 1,365,630	70

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

Facility Name & ID Number Heritage Manor-Litchfield# 0048900

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		\$ 3,551,409	\$ 137,531		\$ 147,204	\$ 9,673	\$ 1,365,630	1
2	Disposal	2005	842						2
3	Electrical Service	2005	8,421						3
4	A/C Units	2005	5,786						4
5	Boiler	2005	3,863						5
6	Exterior Lights	2005	1,095						6
7	Interior Remodel-- paint, wallcoverings	2005	49,155						7
8	Roof	2005	70,055						8
9	Exterior Door	2005	1,158						9
10	adjustments	2005	(4,948)						10
11	Storage Tank Replacement	2006	2,474						11
12	A/C Units	2006	13,308						12
13	Sidewalk	2006	4,566						13
14	A/C Units	2006	1,250						14
15	Exterior Door	2006	30						15
16	Roof	2006	98,093						16
17	adjustments	2006	(13,947)						17
18	HVAC	2007	6,631						18
19	Boiler	2007	1,363						19
20	Fire Panel	2007	2,007						20
21	Corridor Rehab --Paint	2007	32,114						21
22	Rheem Storage Tank	2007	3,422						22
23	Front Entry Doors	2007	4,450						23
24	Fire System	2007	6,769						24
25	Nurse Call	2007	2,565						25
26	Asbestos	2007	253						26
27	adjustments	2007	(6,680)						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,845,504	\$ 137,531		\$ 147,204	\$ 9,673	\$ 1,365,630	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	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		\$ 3,845,504	\$ 137,531		\$ 147,204	\$ 9,673	\$ 1,365,630	1
2	Corridor Rehab-- Paint	2008	11,629						2
3	Electrical Panel	2008							3
4	A/C -- Kitchen & Conf Room	2008	6,660						4
5	HVAC Boiler	2008	11,252						5
6	Exterior Rehab	2008	3,155						6
7	Nurse Call	2008	2,688						7
8	Landscaping	2008							8
9	Siding Laundry	2008	25,650						9
10	Sprinkler	2008	25,062						10
11									11
12	Resident Rm Remodel:paint, flooring & labor	2009	230,727						12
13	Backflow Preventor	2009	5,980						13
14	Windows	2009	38,840						14
15	Sprinkler system	2009	9,386						15
16	Nurse Call	2009	239,661						16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,456,194	\$ 137,531		\$ 147,204	\$ 9,673	\$ 1,365,630	34

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

Facility Name & ID Number Heritage Manor-Litchfield

0048900

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	\$ 540,685	\$ 45,624	\$ 45,624	\$		\$ 447,515	71
72	Current Year Purchases	51,073						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 591,758	\$ 45,624	\$ 45,624	\$		\$ 447,515	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		2009 Turtletop Van	2008	\$ 61,815	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 61,815	\$	\$	\$		\$	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)	\$ 5,116,583	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 183,155	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 192,828	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,673	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,813,145	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: \$ 9,951 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		200		200
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 200	\$	\$ 200
10	SUM OF line 9, col. 1 and 2 (e)	\$	200		

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	\$		\$ 163,796	\$		\$ 163,796	1
2	Licensed Speech and Language Development Therapist		hrs			33,316			33,316	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			139,940	203		140,143	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				148,899		148,899	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					20,381			20,381	13
14	TOTAL			\$		\$ 357,433	\$ 149,102		\$ 506,535	14

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

Facility Name & ID Number Heritage Manor-Litchfield# 0048900Report 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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 15,433	\$	1
2	Cash-Patient Deposits	5,516		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	363,259		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,702		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	895		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 423,805	\$	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)	\$ 423,805	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 125,898	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,516		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	196,115		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,139		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)	\$ 346,668	\$	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)	\$ 346,668	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 77,137	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 423,805	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 57,747	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 57,747	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	19,390	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)	\$ 19,390	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)	\$ 77,137	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Litchfield# 0048900Report 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	\$ 4,361,837	1
2	Discounts and Allowances for all Levels	(1,432,610)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,929,227	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,121,120	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,121,120	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	1,382	12
13	Barber and Beauty Care	15,112	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	260,245	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)	\$ 276,739	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,283	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,283	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)	\$ 4,330,369	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	797,155	31
32	Health Care	2,066,696	32
33	General Administration	963,973	33
B. Capital Expense			
34	Ownership	468,701	34
C. Ancillary Expense			
35	Special Cost Centers	14,454	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)*	\$ 4,310,979	40
41	Income before Income Taxes (line 30 minus line 40)**	19,390	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 19,390	43

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

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

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

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

Facility Name & ID Number **Heritage Manor-Litchfield**

0048900

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	1,500	2,080	\$ 45,279	\$ 21.77	1
2	Assistant Director of Nursing	3,620	3,898	79,684	20.44	2
3	Registered Nurses	1,628	1,867	56,959	30.51	3
4	Licensed Practical Nurses	16,472	17,633	371,333	21.06	4
5	CNAs & Orderlies	61,241	66,532	747,523	11.24	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,819	1,970	30,184	15.32	8
9	Activity Director					9
10	Activity Assistants	3,063	3,432	50,665	14.76	10
11	Social Service Workers	2,373	2,920	40,958	14.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,211	16,433	162,623	9.90	15
16	Dishwashers					16
17	Maintenance Workers	5,084	5,598	65,274	11.66	17
18	Housekeepers	9,180	9,985	101,841	10.20	18
19	Laundry	5,155	5,395	47,300	8.77	19
20	Administrator	1,900	2,080	80,583	38.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,552	8,211	120,218	14.64	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)	135,798	148,034	\$ 2,000,424 *	\$ 13.51	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	16,173		36
37	Medical Records Consultant	600		37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,060		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	1,172		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 21,005		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Marge Oblinger			\$ 80,583	Workers' Compensation Insurance	\$ 45,998	IDPH License Fee	\$ 0		
				Unemployment Compensation Insurance		Advertising: Employee Recruitment	2,768		
				FICA Taxes	174,679	Health Care Worker Background Check (Indicate # of checks performed)	820		
				Employee Health Insurance	164,034	Central Office	8,119		
				Employee Meals			6,641		
				Illinois Municipal Retirement Fund (IMRF)*	0		7,467		
				Other Benefits	16,018	Dues & Subscriptions	7,467		
				Central Office Allocation	32,897	License & Fees	2,628		
							(6,641)		
							(835)		
							(0)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,967	
\$ 80,583				TOTAL (agree to Schedule V, line 22, col.8)			\$ 433,626		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description	Amount			Description	Line #	Amount	Description	Amount	
	\$					\$	Out-of-State Travel	\$	
							In-State Travel		
								3,823	
								141	
							Seminar Expense	2,595	
								0	
							Central Office	9,252	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)		\$ 15,811
\$				\$					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)									
\$ 190,619									

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor-Litchfield# 0048900Report 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 Litchfield 41525 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,845
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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.