

Facility Name & ID Number Heritage Manor-Litchfield

0048900 Report Period Beginning: 1-01-10 Ending: 12-31-10

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,544	7,553	2,961	26,058	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,544	7,553	2,961	26,058	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.99%

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 2,961

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:

1-01-10

Ending:

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V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
1	A. General Services										
1	Dietary	164,344	12,113		176,457		176,457	4,065	180,522		1
2	Food Purchase		182,984		182,984		182,984	(960)	182,024		2
3	Housekeeping	104,589	16,469		121,058		121,058		121,058		3
4	Laundry	45,401	10,483		55,884		55,884		55,884		4
5	Heat and Other Utilities			106,139	106,139		106,139	1,757	107,896		5
6	Maintenance	63,571	51,349	45,548	160,468		160,468	12,103	172,571		6
7	Other (specify):*										7
8	TOTAL General Services	377,905	273,398	151,687	802,990		802,990	16,965	819,955		8
	B. Health Care and Programs										
9	Medical Director			15,881	15,881		15,881	2,986	18,867		9
10	Nursing and Medical Records	1,224,317	91,342	7,640	1,323,299		1,323,299		1,323,299		10
10a	Therapy		179,189	371,639	550,828	(193,983)	356,845	111,823	468,668		10a
11	Activities	51,600	2,151		53,751		53,751	4	53,755		11
12	Social Services	32,721		1,043	33,764		33,764		33,764		12
13	CNA Training							1,348	1,348		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,308,638	272,682	396,203	1,977,523	(193,983)	1,783,540	116,161	1,899,701		16
	C. General Administration										
17	Administrative	85,176			85,176		85,176	86,349	171,525		17
18	Directors Fees										18
19	Professional Services			192,455	192,455		192,455	(172,096)	20,359		19
20	Dues, Fees, Subscriptions & Promotions			87,294	87,294	(55,845)	31,449	(4,642)	26,807		20
21	Clerical & General Office Expenses	114,103	23,238	9,348	146,689		146,689	176,755	323,444		21
22	Employee Benefits & Payroll Taxes			379,700	379,700		379,700	32,433	412,133		22
23	Inservice Training & Education			3,684	3,684		3,684	(1,685)	1,999		23
24	Travel and Seminar			232	232		232	1,767	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			46,105	46,105		46,105	11,602	57,707		26
27	Other (specify):*			677	677		677		677		27
28	TOTAL General Administration	199,279	23,238	719,495	942,012	(55,845)	886,167	130,483	1,016,650		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,885,822	569,318	1,267,385	3,722,525	(249,828)	3,472,697	263,609	3,736,306		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-Litchfield

#0048900

Report Period Beginning:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							219,864	219,864			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,432	7,432		7,432	105,956	113,388			32
33	Real Estate Taxes							79,933	79,933			33
34	Rent-Facility & Grounds			446,760	446,760		446,760	(440,004)	6,756			34
35	Rent-Equipment & Vehicles			16,207	16,207		16,207	1,239	17,446			35
36	Other (specify):*											36
37	TOTAL Ownership			470,399	470,399		470,399	(33,012)	437,387			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					193,983	193,983		193,983			39
40	Barber and Beauty Shops		612	12,200	12,812		12,812		12,812			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		612	12,200	12,812	249,828	262,640		262,640			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,885,822	569,930	1,749,984	4,205,736		4,205,736	230,597	4,436,333			45

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

Facility Name & ID Number Heritage Manor-Litchfield

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Report Period Beginning:

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(3,874)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)	(2,064)	23		16
17	Non-Care Related Fees	(492)	20		17
18	Fines and Penalties				18
19	Entertainment	(6,380)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,741)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(14,605)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (31,156)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	261,753		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 261,753		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 230,597		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Manor-Litchfield

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Report Period Beginning: 1-01-10

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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		(492)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(3,741)	19	22
23				23
24		0	27	24
25		(14,605)	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	(18,838)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Litchfield# 0048900

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	4,065	0	0	0	0	0	0	0	0	4,065	1
2	Food Purchase	0	0	(960)	0	0	0	0	0	0	0	0	(960)	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	1,757	0	0	0	0	0	0	0	0	1,757	5
6	Maintenance	0	0	12,103	0	0	0	0	0	0	0	0	12,103	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	16,965	0	16,965	8							
	B. Health Care and Programs													
9	Medical Director	0	0	2,986	0	0	0	0	0	0	0	0	2,986	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	111,823	0	0	0	0	0	0	0	0	0	111,823	10a
11	Activities	0	0	4	0	0	0	0	0	0	0	0	4	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,348	0	0	0	0	0	0	0	0	1,348	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	111,823	4,338	0	116,161	16							
	C. General Administration													
17	Administrative	0	0	86,349	0	0	0	0	0	0	0	0	86,349	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,741)	(185,985)	17,630	0	0	0	0	0	0	0	0	(172,096)	19
20	Fees, Subscriptions & Promotions	(15,097)	0	10,455	0	0	0	0	0	0	0	0	(4,642)	20
21	Clerical & General Office Expenses	0	0	176,755	0	0	0	0	0	0	0	0	176,755	21
22	Employee Benefits & Payroll Taxes	0	0	32,433	0	0	0	0	0	0	0	0	32,433	22
23	Inservice Training & Education	(2,064)	0	379	0	0	0	0	0	0	0	0	(1,685)	23
24	Travel and Seminar	(6,380)	0	8,147	0	0	0	0	0	0	0	0	1,767	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	11,602	0	0	0	0	0	0	0	0	11,602	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(27,282)	(185,985)	343,750	0	130,483	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,282)	(74,162)	365,053	0	263,609	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Litchfield# 0048900

Report Period Beginning:

1-01-10

Ending:

12-31-10

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	210,162	0	9,702	0	0	0	0	0	0	0	219,864	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,874)	109,214	0	616	0	0	0	0	0	0	0	105,956	32
33	Real Estate Taxes	0	79,877	0	56	0	0	0	0	0	0	0	79,933	33
34	Rent-Facility & Grounds	0	(446,760)	0	6,756	0	0	0	0	0	0	0	(440,004)	34
35	Rent-Equipment & Vehicles	0	0	0	1,239	0	0	0	0	0	0	0	1,239	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,874)	(47,507)	0	18,369	0	(33,012)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(31,156)	(121,669)	365,053	18,369	0	230,597	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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$		1
2	V	10a Adjustment for Related Organization		GreenTree Pharmacy	0.00%	111,823	111,823	2
3	V							3
4	V	19 Adjustment for Related Organization	185,985	Heritage Operations Group, LLC	0.00%		(185,985)	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		79,877	79,877	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		103,927	103,927	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		210,162	210,162	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,287	5,287	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 632,745			\$ 511,076	\$ * (121,669)	14

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

Facility Name & ID Number

Heritage Manor-Litchfield

0048900

Report Period Beginning:

1-01-10

Ending:

12-31-10

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.		\$	4,065	15
16	V	2 Food Purchase					(960)	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,757	19
20	V	6 Maintenance					12,103	20
21	V	7 Other					0	21
22	V	9 Medical Director					2,986	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					4	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,348	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					86,349	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					17,630	31
32	V	20 Fees, Subscription, Promotions					10,455	32
33	V	21 Clerical & General Office Expenses					176,755	33
34	V	22 Employee Benefits & Payroll Taxes					32,433	34
35	V	23 Inservice Training & Education					379	35
36	V	24 Travel and Seminar					8,147	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					11,602	38
39	Total		\$			\$	0	\$ * 365,053 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:

1-01-10

Ending: 12-31-10

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 15
16	V	30	Depreciation						9,702 16
17	V	31	Amortization of Pre-Op & Org						0 17
18	V	32	Interest						616 18
19	V	33	Real Estate Taxes						56 19
20	V	34	Rent-Facility & Grounds						6,756 20
21	V	35	Rent-Equipment & Vehicles						1,239 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								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			\$	0	\$ * 18,369 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:

1-01-10

Ending:

12-31-10

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:

1-01-10

Ending: 12-31-10

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	\$ 104,969	\$ 104,969	102	\$ 4,065	1
2	2	Food Purchase	Beds	2,634	25	(24,794)	0	102	(960)	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	45,364	0	102	1,757	5
6	6	Maintenance	Beds	2,634	25	312,555	75,007	102	12,103	6
7	7	Other	Beds	2,634	25	0	0	102	0	7
8	9	Medical Director	Beds	2,634	25	77,111	0	102	2,986	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	77,111	102	0	9
10	11	Activities	Beds	2,634	25	95	0	102	4	10
11	12	Social Service	Beds	2,634	25	0	0	102	0	11
12	13	Nurse Aide Training	Beds	2,634	25	34,804	0	102	1,348	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	2,229,831	2,229,831	102	86,349	15
16	18	Directors Fees	Beds	2,634	25	0	0	102	0	16
17	19	Professional Services	Beds	2,634	25	455,276	0	102	17,630	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	269,994	0	102	10,455	18
19	21	Clerical & General Office Expens	Beds	2,634	25	4,564,447	4,163,572	102	176,755	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	837,533	0	102	32,433	20
21	23	Inservice Training & Education	Beds	2,634	25	9,793	0	102	379	21
22	24	Travel and Seminar	Beds	2,634	25	210,373	0	102	8,147	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	299,608	0	102	11,602	24
25	TOTALS					\$ 9,426,959	\$ 6,650,490		\$ 365,053	25

Facility Name & ID Number Heritage Manor-Litchfield

0048900

Report Period Beginning:

1-01-10

Ending: 12-31-10

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	250,538	102	9,702	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		102		3
4	32	Interest	Beds	2,634	25	15,900	102	616	4
5	33	Real Estate Taxes	Beds	2,634	25	1,448	102	56	5
6	34	Rent-Facility & Grounds	Beds	2,634	25	174,472	102	6,756	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	31,994	102	1,239	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					\$ 474,352	\$	\$ 18,369	25

Facility Name & ID Number

Heritage Manor-Litchfield

0048900

Report Period Beginning:

1-01-10

Ending:

12-31-10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		xx	Mortgage			\$	\$ 1,605,793	3/2011	variable	\$ 103,927	1
2	Bank of America		xx	Loan Fees							5,287	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							7,432	6
7												7
8												8
9	TOTAL Facility Related						\$	\$ 1,605,793			\$ 116,646	9
	B. Non-Facility Related*											
10	Interest Income										(3,874)	10
11	Allocated Corporate										616	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (3,258)	14
15	TOTALS (line 9+line14)						\$	\$ 1,605,793			\$ 113,388	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 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.)		\$	79,877	2
3. Under or (over) accrual (line 2 minus line 1).		\$	79,877	3
4. Real Estate Tax accrual used for 2010 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.		\$	79,877	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	60,060	8
	2006	66,801	9
	2007	69,159	10
	2008	73,365	11
	2009	79,877	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Litchfield COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0048900

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>1504279009</u>	<u>nursing home</u>	\$ <u>75,661.00</u>	\$ <u>75,661.00</u>
2. <u>1504278012</u>	<u>_____</u>	\$ <u>222.00</u>	\$ <u>222.00</u>
3. <u>1504279015</u>	<u>_____</u>	\$ <u>3,994.00</u>	\$ <u>3,994.00</u>
4. _____	<u>_____</u>	\$ _____	\$ _____
5. _____	<u>_____</u>	\$ _____	\$ _____
6. _____	<u>_____</u>	\$ _____	\$ _____
7. _____	<u>_____</u>	\$ _____	\$ _____
8. _____	<u>_____</u>	\$ _____	\$ _____
9. _____	<u>_____</u>	\$ _____	\$ _____
10. _____	<u>_____</u>	\$ _____	\$ _____
	TOTALS	\$ <u><u>79,877.00</u></u>	\$ <u><u>79,877.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Heritage Manor-Litchfield

0048900 Report Period Beginning:

1-01-10 Ending:

12-31-10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,102 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				\$ 6,816	1
2					2
3	TOTALS			\$ 6,816	3

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	\$		\$	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9	Symmons Mixing Valve		1997		2,000					
10	Boiler		1997		5,612					
11	Dinning Room Roof Repair		1997		2,755					
12	Roof Repair		1997		3,280					
13										
14	Laundry Room Central Air		1996		3,019					
15	Heritage Manor Sign		1996		2,173					
16										
17	Roof		1998		60,674					
18	Booster Heater		1998		1,717					
19	Heat/Cool Units		1998		3,433					
20	Garbage Disposal		1998		730					
21										
22										
23										
24										
25										
26			1999		920					
27	Recirculating Pump		1999		2,046					
28	Plumbing repairs/Replacement		1999		10,045					
29	Carpet		1999		2,335					
30	Interior Painting--Materials and Labor									
31	Water Heater									
32										
33	C/O Allocation							9,702	9,702	
34	Book Depreciation					156,744		156,744		
35										
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:

1-01-10

Ending:

12-31-10**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 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	\$ 156,744		\$ 166,446	\$ 9,702	\$	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:

1-01-10

Ending:

12-31-10**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	10
	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	\$ 156,744		\$ 166,446	\$ 9,702		1
2	<u>Disposal</u>	2005	842						2
3	<u>Electrical Service</u>	2005	8,421						3
4	<u>A/C Units</u>	2005	5,786						4
5	<u>Boiler</u>	2005	3,863						5
6	<u>Exterior Lights</u>	2005	1,095						6
7	<u>Interior Remodel-- paint, wallcoverings</u>	2005	49,155						7
8	<u>Roof</u>	2005	70,055						8
9	<u>Exterior Door</u>	2005	1,158						9
10	<u>adjustments</u>	2005	(4,948)						10
11	<u>Storage Tank Replacement</u>	2006	2,474						11
12	<u>A/C Units</u>	2006	13,308						12
13	<u>Sidewalk</u>	2006	4,566						13
14	<u>A/C Units</u>	2006	1,250						14
15	<u>Exterior Door</u>	2006	30						15
16	<u>Roof</u>	2006	98,093						16
17	<u>adjustments</u>	2006	(13,947)						17
18	<u>HVAC</u>	2007	6,631						18
19	<u>Boiler</u>	2007	1,363						19
20	<u>Fire Panel</u>	2007	2,007						20
21	<u>Corridor Rehab --Paint</u>	2007	32,114						21
22	<u>Rheem Storage Tank</u>	2007	3,422						22
23	<u>Front Entry Doors</u>	2007	4,450						23
24	<u>Fire System</u>	2007	6,769						24
25	<u>Nurse Call</u>	2007	2,565						25
26	<u>Asbestos</u>	2007	253						26
27	<u>adjustments</u>	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	\$ 156,744		\$ 166,446	\$ 9,702	\$	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:

1-01-10

Ending:

12-31-10**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		\$ 3,845,504	\$ 156,744		\$ 166,446	\$ 9,702		1
2	2008	11,629						2
3	2008							3
4	2008	6,660						4
5	2008	11,252						5
6	2008	3,155						6
7	2008	2,688						7
8	2008							8
9	2008	25,650						9
10	2008	25,062						10
11								11
12	2009	230,727						12
13	2009	5,980						13
14	2009	38,840						14
15	2009	9,386						15
16	2009	239,661						16
17								17
18	2010	14,010						18
19	2010	17,868						19
20	2010	4,500						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		\$ 4,492,572	\$ 156,744		\$ 166,446	\$ 9,702	\$	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		\$ 4,492,572	\$ 156,744		\$ 166,446	\$ 9,702		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,492,572	\$ 156,744		\$ 166,446	\$ 9,702	\$	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:

1-01-10

Ending:

12-31-10

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	\$ 653,573	\$ 53,418	\$ 53,418	\$		\$	71
72	Current Year Purchases	134,164						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 787,737	\$ 53,418	\$ 53,418	\$		\$	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)	\$ 5,287,125	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 210,162	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 219,864	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,702	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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.

Facility Name & ID Number Heritage Manor-Litchfield

0048900

Report Period Beginning: 1-01-10

Ending: 12-31-10

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

Table with 8 columns: 1 Year Constructed, 2 Number of Beds, 3 Original Lease Date, 4 Rental Amount, 5 Total Years of Lease, 6 Total Years Renewal Option*, 7 (blank), 8 (blank). Rows include Original Building, Additions, and TOTAL.

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 [X] NO

16. Rental Amount for movable equipment: \$ 16,207 Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

Table with 5 columns: 1 Use, 2 Model Year and Make, 3 Monthly Lease Payment, 4 Rental Expense for this Period, 5 (blank). Rows 17-21 include a TOTAL row.

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

Table with 2 columns: Fiscal Year Ending, Annual Rent. Rows 12, 13, 14 for years /2011, /2012, /2013.

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
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	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 169,302	\$		\$ 169,302	1
2	Licensed Speech and Language Development Therapist		hrs			36,259			36,259	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			150,823	461		151,284	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				178,728		178,728	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					15,255			15,255	13
14	TOTAL			\$		\$ 371,639	\$ 179,189		\$ 550,828	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: 1-01-10

Ending:

12-31-10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-10

(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	\$ 8,014	\$	1
2	Cash-Patient Deposits	6,740		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	301,695		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,871		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	97,781		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 450,101	\$	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)	\$ 450,101	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 151,899	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,740		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	224,049		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,885		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)	\$ 400,573	\$	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)	\$ 400,573	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 49,528	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 450,101	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (72,864)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (72,864)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	122,392	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)	\$ 122,392	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)	\$ 49,528	24 *

* This must agree with page 17, line 47.

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	\$ 4,232,565	1
2	Discounts and Allowances for all Levels	(1,397,079)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,835,486	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,161,270	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,161,270	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	1,003	12
13	Barber and Beauty Care	13,184	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	317,926	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)	\$ 332,113	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,874	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,874	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other</u>	(4,615)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (4,615)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,328,128	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	802,990	31
32	Health Care	1,977,523	32
33	General Administration	942,012	33
B. Capital Expense			
34	Ownership	470,399	34
C. Ancillary Expense			
35	Special Cost Centers	12,812	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)*	\$ 4,205,736	40
41	Income before Income Taxes (line 30 minus line 40)**	122,392	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 122,392	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:

1-01-10

Ending:

12-31-10

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	\$ 57,800	\$ 27.79	1
2	Assistant Director of Nursing	800	800	24,094	30.12	2
3	Registered Nurses	1,628	1,867	62,674	33.57	3
4	Licensed Practical Nurses	16,472	17,633	383,477	21.75	4
5	CNAs & Orderlies	61,241	66,532	689,296	10.36	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	400	400	6,976	17.44	8
9	Activity Director					9
10	Activity Assistants	3,063	3,432	51,600	15.03	10
11	Social Service Workers	2,373	2,920	32,721	11.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,211	16,433	164,344	10.00	15
16	Dishwashers					16
17	Maintenance Workers	5,084	5,598	63,571	11.36	17
18	Housekeepers	9,180	9,985	104,589	10.47	18
19	Laundry	5,155	5,395	45,401	8.42	19
20	Administrator	1,900	2,080	85,176	40.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,552	8,211	114,103	13.90	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)	131,559	143,366	\$ 1,885,822 *	\$ 13.15	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	15,881		36
37	Medical Records Consultant	275		37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,120		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	1,043		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 23,319		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

Facility Name & ID Number Heritage Manor-Litchfield

Report Period Beginning: 1-01-10 Ending: 12-31-10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heritage Manor-Litchfield# 0048900

Report Period Beginning:

1-01-10Ending: 12-31-10**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? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 2,383
- (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.

Heritage Facility Listing

113	Heritage Manor - South	8306 St. Lukes Drive	Beardstown, IL 62618
104	Heritage Manor - Bloom	700 East Walnut	Bloomington, IL 61701
126	Heritage Manor - Carlin	1200 University Avenue	Carlinville, IL 62626
137	Heritage Manor - Chillico	1028 Hillcrest Drive	Chillicothe, IL 61523
119	Heritage Manor - Dwight	300 East Mazon Ave.	Dwight, IL 60420
116	Heritage Manor - Elgin,	355 Raymond Street	Elgin, IL 60120
114	Heritage Manor - El Paso	555 E. Clay Street	El Paso, IL 61738
105	Heritage Manor - Gibson	620 East 1st Street	Gibson City, IL 60936
127	Heritage Manor - Gilles	7588 Staunton Road	Gillespie, IL 62033
149	Heritage Manor - LaSalle	1445 Chartres	LaSalle, IL 61301
128	Heritage Manor - Litchfield	628 South Illinois Street	Litchfield, IL 62056
108	Heritage Manor - Mendota	1201 First Avenue	Mendota, IL 61342
124	Heritage Manor - Minonk	201 Locust	Minonk, IL 61760
112	Heritage Manor - Mt. Sterling	435 Camden Road	Mount Sterling, IL 62353
138	Heritage Manor - Mt. Zion	1225 Woodland Drive	Mount Zion, IL 62549
109	Heritage Manor - Normal	509 N. Adelaide	Normal, IL 61761
129	Heritage Manor - Pana,	1000 E. Sixth Street Rd	Pana, IL 62557
106	Heritage Manor - Peru,	1301 21st Street	Peru, IL 61354
130	Heritage Manor - Staunton	215 W. Pennsylvania Ave	Staunton, IL 62088
107	Heritage Manor - Streator	1525 East Main Street	Streator, IL 61364
139	Barton W. Stone Jacksonville	873 Grove St	Jacksonville, IL 62650
134	Danville Joint Ventures,	620 Warrington Avenue	Danville, IL 61832-5446