

Facility Name & ID Number Heritage Manor Litchfield, LLC.

48900 Report Period Beginning: 01/01/11 Ending: 12/31/11

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,591	7,961	3,644	29,196	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,591	7,961	3,644	29,196	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.42%

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 July 2007

J. Was the facility purchased or leased after January 1, 1978?
YES Date July 2007 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided 3,644

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, LLC.

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Report Period Beginning:

01/01/11

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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
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	180,879	11,617		192,496		192,496	5,723	198,219		1
2	Food Purchase		198,209		198,209		198,209	19	198,228		2
3	Housekeeping	112,198	19,255		131,453		131,453	8	131,461		3
4	Laundry	47,730	10,681		58,411		58,411	6	58,417		4
5	Heat and Other Utilities			107,456	107,456		107,456	2,016	109,472		5
6	Maintenance	65,286	36,777	36,516	138,579		138,579	14,834	153,413		6
7	Other (specify):*										7
8	TOTAL General Services	406,093	276,539	143,972	826,604		826,604	22,606	849,210		8
	B. Health Care and Programs										
9	Medical Director			31,264	31,264		31,264	82	31,346		9
10	Nursing and Medical Records	1,383,671	104,988	7,455	1,496,114		1,496,114		1,496,114		10
10a	Therapy		294,194	446,246	740,440	(312,937)	427,503	81,242	508,745		10a
11	Activities	50,045	2,189		52,234		52,234		52,234		11
12	Social Services	49,537		2,547	52,084		52,084		52,084		12
13	CNA Training		996		996		996	821	1,817		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,483,253	402,367	487,512	2,373,132	(312,937)	2,060,195	82,145	2,142,340		16
	C. General Administration										
17	Administrative	89,896			89,896		89,896	87,083	176,979		17
18	Directors Fees										18
19	Professional Services			210,672	210,672		210,672	(200,263)	10,409		19
20	Dues, Fees, Subscriptions & Promotions			88,021	88,021	(55,845)	32,176	(11,461)	20,715		20
21	Clerical & General Office Expenses	101,623	24,308	9,966	135,897		135,897	192,140	328,037		21
22	Employee Benefits & Payroll Taxes			432,712	432,712		432,712	40,400	473,112		22
23	Inservice Training & Education			536	536		536	502	1,038		23
24	Travel and Seminar			7,223	7,223		7,223	(5,224)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			44,853	44,853		44,853	11,839	56,692		26
27	Other (specify):*			195	195		195		195		27
28	TOTAL General Administration	191,519	24,308	794,178	1,010,005	(55,845)	954,160	115,016	1,069,176		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,080,865	703,214	1,425,662	4,209,741	(368,782)	3,840,959	219,767	4,060,726		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, LLC.

#48900

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							243,291	243,291			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,950	9,950		9,950	101,121	111,071			32
33	Real Estate Taxes							72,170	72,170			33
34	Rent-Facility & Grounds			446,760	446,760		446,760	(445,787)	973			34
35	Rent-Equipment & Vehicles			8,879	8,879		8,879	950	9,829			35
36	Other (specify):*											36
37	TOTAL Ownership			465,589	465,589		465,589	(28,255)	437,334			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					312,937	312,937		312,937			39
40	Barber and Beauty Shops		534	14,101	14,635		14,635		14,635			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		534	14,101	14,635	368,782	383,417		383,417			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,080,865	703,748	1,905,352	4,689,965		4,689,965	191,512	4,881,477			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, LLC.

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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	(417)	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)		23		16
17	Non-Care Related Fees	(687)	20		17
18	Fines and Penalties				18
19	Entertainment	(14,903)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(945)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(16,415)	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)	\$ (33,367)		\$	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)	224,879		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 224,879		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 191,512		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, LLC.

ID# 48900

Report Period Beginning: 01/01/11

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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		(687)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(945)	19	22
23				23
24		0	27	24
25		(16,415)	20	25
26				26
27				27
28				28
29			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	(18,047)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Litchfield, LLC.

48900

Report Period Beginning:

01/01/11

Ending:

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	5,723	0	0	0	0	0	0	0	0	5,723	1
2	Food Purchase	0	0	19	0	0	0	0	0	0	0	0	19	2
3	Housekeeping	0	0	8	0	0	0	0	0	0	0	0	8	3
4	Laundry	0	0	6	0	0	0	0	0	0	0	0	6	4
5	Heat and Other Utilities	0	0	2,016	0	0	0	0	0	0	0	0	2,016	5
6	Maintenance	0	0	14,834	0	0	0	0	0	0	0	0	14,834	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	22,606	0	22,606	8							
	B. Health Care and Programs													
9	Medical Director	0	0	82	0	0	0	0	0	0	0	0	82	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	81,242	0	0	0	0	0	0	0	0	0	81,242	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	821	0	0	0	0	0	0	0	0	821	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	81,242	903	0	82,145	16							
	C. General Administration													
17	Administrative	0	0	87,083	0	0	0	0	0	0	0	0	87,083	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(945)	(209,727)	10,409	0	0	0	0	0	0	0	0	(200,263)	19
20	Fees, Subscriptions & Promotions	(17,102)	0	5,641	0	0	0	0	0	0	0	0	(11,461)	20
21	Clerical & General Office Expenses	0	0	192,140	0	0	0	0	0	0	0	0	192,140	21
22	Employee Benefits & Payroll Taxes	0	0	40,400	0	0	0	0	0	0	0	0	40,400	22
23	Inservice Training & Education	0	0	502	0	0	0	0	0	0	0	0	502	23
24	Travel and Seminar	(14,903)	0	9,679	0	0	0	0	0	0	0	0	(5,224)	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	11,839	0	0	0	0	0	0	0	0	11,839	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(32,950)	(209,727)	357,693	0	115,016	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,950)	(128,485)	381,202	0	219,767	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Litchfield, LLC.

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Report Period Beginning:

01/01/11

Ending:

12/31/11

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	231,273	0	12,018	0	0	0	0	0	0	0	243,291 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(417)	100,922	0	616	0	0	0	0	0	0	0	101,121 32
33	Real Estate Taxes	0	72,170	0	0	0	0	0	0	0	0	0	72,170 33
34	Rent-Facility & Grounds	0	(446,760)	0	973	0	0	0	0	0	0	0	(445,787) 34
35	Rent-Equipment & Vehicles	0	0	0	950	0	0	0	0	0	0	0	950 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(417)	(42,395)	0	14,557	0	(28,255) 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)	(33,367)	(170,880)	381,202	14,557	0	191,512 45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 Page 25				

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%	81,242	81,242	2
3	V							3
4	V	19 Adjustment for Related Organization	209,727	Heritage Operations Group, LLC	0.00%		(209,727)	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		72,170	72,170	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		96,144	96,144	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		231,273	231,273	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		4,778	4,778	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 656,487			\$ 485,607	\$ * (170,880)	14

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

Facility Name & ID Number Heritage Manor Litchfield, LLC.

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Report Period Beginning: 01/01/11

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VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.		\$	5,723	15
16	V	2 Food Purchase					19	16
17	V	3 Housekeeping					8	17
18	V	4 Laundry					6	18
19	V	5 Heat & Other Utilities					2,016	19
20	V	6 Maintenance					14,834	20
21	V	7 Other					0	21
22	V	9 Medical Director					82	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					0	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					821	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					87,083	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					10,409	31
32	V	20 Fees, Subscription, Promotions					5,641	32
33	V	21 Clerical & General Office Expenses					192,140	33
34	V	22 Employee Benefits & Payroll Taxes					40,400	34
35	V	23 Inservice Training & Education					502	35
36	V	24 Travel and Seminar					9,679	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					11,839	38
39	Total		\$			\$	0	\$ * 381,202 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	15
16	V	30	Depreciation					12,018	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					616	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					973	20
21	V	35	Rent-Equipment & Vehicles					950	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	\$ * 14,557 39

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

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Ending:

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

Facility Name & ID Number Heritage Manor Litchfield, LLC. # 48900 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	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, LLC.

48900

Report Period Beginning:

01/01/11

Ending: 12/31/11

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	2,735	26	\$ 153,442	\$ 153,115	102	\$ 5,723	1
2	2	Food Purchase	Beds	2,735	26	520	0	102	19	2
3	3	Housekeeping	Beds	2,735	26	215	0	102	8	3
4	4	Laundry	Beds	2,735	26	151	0	102	6	4
5	5	Heat & Other Utilities	Beds	2,735	26	54,054	0	102	2,016	5
6	6	Maintenance	Beds	2,735	26	397,756	75,127	102	14,834	6
7	7	Other	Beds	2,735	26	0	0	102	0	7
8	9	Medical Director	Beds	2,735	26	2,206	0	102	82	8
9	10	Nursing & Medical Records	Beds	2,735	26	0	0	102	0	9
10	11	Activities	Beds	2,735	26	0	0	102	0	10
11	12	Social Service	Beds	2,735	26	0	0	102	0	11
12	13	Nurse Aide Training	Beds	2,735	26	22,009	20,793	102	821	12
13	14	Program Transportation	Beds	2,735	26	0	0	102	0	13
14	15	Other	Beds	2,735	26	0	0	102	0	14
15	17	Administrative	Beds	2,735	26	2,335,023	2,335,023	102	87,083	15
16	18	Directors Fees	Beds	2,735	26	0	0	102	0	16
17	19	Professional Services	Beds	2,735	26	279,109	0	102	10,409	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	151,258	0	102	5,641	18
19	21	Clerical & General Office Expens	Beds	2,735	26	5,151,979	4,517,846	102	192,140	19
20	22	Employee Benefits & Payroll Tax	Beds	2,735	26	1,083,278	0	102	40,400	20
21	23	Inservice Training & Education	Beds	2,735	26	13,460	0	102	502	21
22	24	Travel and Seminar	Beds	2,735	26	259,533	0	102	9,679	22
23	25	Other Admin. Staff Transportatio	Beds	2,735	26	0	0	102	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	317,454	0	102	11,839	24
25	TOTALS					\$ 10,221,447	\$ 7,101,904		\$ 381,202	25

Facility Name & ID Number Heritage Manor Litchfield, LLC.

48900

Report Period Beginning:

01/01/11

Ending: 12/31/11

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	27	Other	Beds	2,735	26	\$	102	\$	1
2	30	Depreciation	Beds	2,735	26	322,258	102	12,018	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26		102		3
4	32	Interest	Beds	2,735	26	16,517	102	616	4
5	33	Real Estate Taxes	Beds	2,735	26		102		5
6	34	Rent-Facility & Grounds	Beds	2,735	26	26,080	102	973	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	25,461	102	950	7
8	36	Other	Beds	2,735	26		102		8
9	38	Medically Nec Transportation	Beds	2,735	26		102		9
10	39	Ancillary Service Centers	Beds	2,735	26		102		10
11	40	Barber and Beauty Shops	Beds	2,735	26		102		11
12	41	Coffee and Gift Shops	Beds	2,735	26		102		12
13	42	Other	Beds	2,735	26		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					\$ 390,316	\$	\$ 14,557	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10			
										Related**		Purpose of Loan
Name of Lender	YES	NO	Original	Balance								
A. Directly Facility Related												
Long-Term												
1	Busey Bank		xx	Mortgage			\$	\$ 1,488,473	03/2016	variable	\$ 96,144	1
2	Busey Bank		xx	Loan Fees							4,778	2
3												3
4												4
5												5
Working Capital												
6	Bank of America		xx	Accounts Receivable							9,950	6
7												7
8												8
9	TOTAL Facility Related						\$	\$ 1,488,473			\$ 110,872	9
B. Non-Facility Related*												
10	Interest Income										(417)	10
11	Allocated Corporate										616	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 199	14
15	TOTALS (line 9+line14)						\$	\$ 1,488,473			\$ 111,071	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.)

Facility Name & ID Number Heritage Manor Litchfield, LLC.

48900

Report Period Beginning:

01/01/11

Ending:

12/31/11

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 2010 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.)			\$	72,170 2
3.	Under or (over) accrual (line 2 minus line 1).			\$	72,170 3
4.	Real Estate Tax accrual used for 2011 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.			\$	72,170 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	60,060	8	
		2007	66,801	9	
		2008	69,159	10	
		2009	73,365	11	
		2010	72,170	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor Litchfield, LLC. COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 48900

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 2010 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 2010.

(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>68,999.00</u>	\$ <u>68,999.00</u>
2. <u>1504278012</u>	_____	\$ <u>227.00</u>	\$ <u>227.00</u>
3. <u>1504279015</u>	_____	\$ <u>2,944.00</u>	\$ <u>2,944.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>72,170.00</u></u>	\$ <u><u>72,170.00</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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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, LLC.

48900

Report Period Beginning:

01/01/11 Ending:

12/31/11

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:

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

Facility Name & ID Number Heritage Manor Litchfield, LLC.

48900

Report Period Beginning:

01/01/11

Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	C/O Allocation						12,018	12,018	33
34	Book Depreciation				162,575		162,575		34
35									35
36									36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Heritage Manor Litchfield, LLC.# 48900

Report Period Beginning:

01/01/11

Ending:

12/31/11**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	\$ 162,575		\$ 174,593	\$ 12,018	\$	70

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

Facility Name & ID Number Heritage Manor Litchfield, LLC.# 48900

Report Period Beginning:

01/01/11

Ending:

12/31/11**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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		\$ 3,551,409	\$ 162,575		\$ 174,593	\$ 12,018	\$
2	2005	842					
3	2005	8,421					
4	2005	5,786					
5	2005	3,863					
6	2005	1,095					
7	2005	49,155					
8	2005	70,055					
9	2005	1,158					
10	2005	(4,948)					
11	2006	2,474					
12	2006	13,308					
13	2006	4,566					
14	2006	1,250					
15	2006	30					
16	2006	98,093					
17	2006	(13,947)					
18	2007	6,631					
19	2007	1,363					
20	2007	2,007					
21	2007	32,114					
22	2007	3,422					
23	2007	4,450					
24	2007	6,769					
25	2007	2,565					
26	2007	253					
27	2007	(6,680)					
28							
29							
30							
31							
32							
33							
34		\$ 3,845,504	\$ 162,575		\$ 174,593	\$ 12,018	\$

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

Facility Name & ID Number Heritage Manor Litchfield, LLC.# 48900

Report Period Beginning:

01/01/11

Ending:

12/31/11**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	\$ 162,575		\$ 174,593	\$ 12,018	\$
2	2008	11,629					
3	2008						
4	2008	6,660					
5	2008	11,252					
6	2008	3,155					
7	2008	2,688					
8	2008						
9	2008	25,650					
10	2008	25,062					
11							
12	2009	230,727					
13	2009	5,980					
14	2009	38,840					
15	2009	9,386					
16	2009	239,661					
17							
18	2010	14,010					
19	2010	17,868					
20	2010	4,500					
21							
22	2011	4,680					
23	2011	3,276					
24	2011	13,603					
25	2011	4,025					
26	2011	40,675					
27							
28							
29							
30							
31							
32							
33							
34		\$ 4,558,831	\$ 162,575		\$ 174,593	\$ 12,018	\$

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

Facility Name & ID Number Heritage Manor Litchfield, LLC.

48900

Report Period Beginning:

01/01/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ <u>787,737</u>	\$ <u>68,698</u>	\$ <u>68,698</u>	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ <u>787,737</u>	\$ <u>68,698</u>	\$ <u>68,698</u>	\$		\$	75

D. Vehicle Costs. (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)		\$ 5,353,384	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 231,273	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 243,291	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 12,018	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.

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: \$ 8,879 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. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

* 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		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		996		996
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	\$	\$ 996	\$	\$ 996
10	SUM OF line 9, col. 1 and 2 (e)	\$	996		

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	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
DROP-OUTS	
1. From this facility	<input style="width: 100px;" type="text"/>
2. From other facilities (f)	<input style="width: 100px;" type="text"/>
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		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	187,679	\$		\$	187,679	1
2	Licensed Speech and Language Development Therapist		hrs				49,465				49,465	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs				190,055		304		190,359	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						293,890		293,890	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						19,047				19,047	13
14	TOTAL			\$		\$	446,246	\$	294,194	\$	740,440	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, LLC.

48900

Report Period Beginning: 01/01/11

Ending:

12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(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	\$ 19,076	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	647,854		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,819		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(188,421)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 519,328	\$	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)	\$ 519,328	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 174,540	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	215,255		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,445		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)	\$ 391,240	\$	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)	\$ 391,240	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 128,088	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 519,328	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (150,472)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (150,472)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	278,560	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)	\$ 278,560	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)	\$ 128,088	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	\$ 4,695,802	1
2	Discounts and Allowances for all Levels	(1,730,714)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,965,088	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,466,575	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,466,575	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	1,063	12
13	Barber and Beauty Care	15,317	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	520,065	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)	\$ 536,445	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	417	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 417	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)	\$ 4,968,525	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	826,604	31
32	Health Care	2,373,132	32
33	General Administration	1,010,005	33
B. Capital Expense			
34	Ownership	465,589	34
C. Ancillary Expense			
35	Special Cost Centers	14,635	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)*	\$ 4,689,965	40
41	Income before Income Taxes (line 30 minus line 40)**	278,560	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 278,560	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, LLC.

48900

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	1,856	2,025	\$ 62,180	\$ 30.71	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	2,866	2,953	77,351	26.19	3
4	Licensed Practical Nurses	20,457	21,149	471,388	22.29	4
5	CNAs & Orderlies	59,897	62,458	772,752	12.37	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	3,624	3,816	50,045	13.11	10
11	Social Service Workers	2,829	2,976	49,537	16.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,711	16,226	180,879	11.15	15
16	Dishwashers					16
17	Maintenance Workers	5,138	5,527	65,286	11.81	17
18	Housekeepers	10,834	11,195	112,198	10.02	18
19	Laundry	5,225	5,363	47,730	8.90	19
20	Administrator	1,900	2,080	89,896	43.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,595	7,088	101,623	14.34	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)	136,932	142,856	\$ 2,080,865 *	\$ 14.57	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	31,264		36
37	Medical Records Consultant	812		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	2,547		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 40,743		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-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, LLC.# 48900Report Period Beginning: 01/01/11Ending: 12/31/11**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? 7 years
- (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 x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES xx 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. \$ 4,165
- (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

FACILITY Owned SNFs	STATE LICENSE NUMBER
Heritage Health - South, LLC	48843
Heritage Health - Bloomington, LLC	48157
Heritage Health - Carlinville, LLC	48850
Heritage Health - Chillicothe, LLC	48868
Heritage Health - Dwight, LLC	50492
Heritage Health - Elgin, LLC	48132
Heritage Health - El Paso, LLC	48124
Heritage Health - Gibson City, LLC	48116
Heritage Health - Gillespie, LLC	48892
Heritage Health - LaSalle, LLC	51276
Heritage Health - Litchfield, LLC	48900
Heritage Health - Mendota, LLC	48108
Heritage Health - Minonk, LLC	48058
Heritage Health - Mt. Sterling, LLC	48041
Heritage Health - Mt. Zion, LLC	48074
Heritage Health - Normal, LLC	48082
Heritage Health - Pana, LLC	48884
Heritage Health - Peru, LLC	48090
Heritage Health - Staunton, LLC	48876
Heritage Health - Streator, LLC	48066
Barton W. Stone Jacksonville, LLC	48918
Danville Joint Ventures, LLC d/b/aColonial Manor	42168
Heritage Health - Springfield	41699
Cotillion Ridge	45138
Country Health	7880
Mason City Area NH	34256
St. Clara's Manor	50724
Vonderlieth Living Center	19976