

Facility Name & ID Number Heritage Manor-Bloomington# 0048157 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>111</u>	Skilled (SNF)	<u>111</u>	<u>40,515</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>111</u>	TOTALS	<u>111</u>	<u>40,515</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>20,403</u>	<u>8,261</u>	<u>4,169</u>	<u>32,833</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,403</u>	<u>8,261</u>	<u>4,169</u>	<u>32,833</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.04%

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)

noneF. 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 07/2006

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

YES Date 07/2006 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided 4,169Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL 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-Bloomington # 0048157 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	260,031	27,752		287,783		287,783	6,110	293,893		1
2	Food Purchase		187,265		187,265		187,265		187,265		2
3	Housekeeping	85,373	26,951		112,324		112,324	23	112,347		3
4	Laundry	75,694	13,261		88,955		88,955		88,955		4
5	Heat and Other Utilities			142,395	142,395		142,395	2,150	144,545		5
6	Maintenance	103,183	76,352	60,418	239,953		239,953	15,301	255,254		6
7	Other (specify):*										7
8	TOTAL General Services	524,281	331,581	202,813	1,058,675		1,058,675	23,584	1,082,259		8
	B. Health Care and Programs										
9	Medical Director			14,200	14,200		14,200	2,494	16,694		9
10	Nursing and Medical Records	1,711,855	185,608	334,849	2,232,312		2,232,312		2,232,312		10
10a	Therapy		321,472	689,314	1,010,786	(335,127)	675,659	185,153	860,812		10a
11	Activities	73,068	2,342		75,410		75,410	1,606	77,016		11
12	Social Services	46,105	88	2,627	48,820		48,820		48,820		12
13	CNA Training	11,592	3,907		15,499		15,499	1,270	16,769		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,842,620	513,417	1,040,990	3,397,027	(335,127)	3,061,900	190,523	3,252,423		16
	C. General Administration										
17	Administrative	67,356			67,356		67,356	77,366	144,722		17
18	Directors Fees							8,241	8,241		18
19	Professional Services			260,959	260,959		260,959	(250,152)	10,807		19
20	Dues, Fees, Subscriptions & Promotions			135,174	135,174	(60,773)	74,401	(1,968)	72,433		20
21	Clerical & General Office Expenses	210,774	26,837	15,078	252,689		252,689	173,595	426,284		21
22	Employee Benefits & Payroll Taxes			549,907	549,907		549,907	35,477	585,384		22
23	Inservice Training & Education			6,402	6,402		6,402	(4,403)	1,999		23
24	Travel and Seminar			2,728	2,728		2,728	(729)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			60,708	60,708		60,708	12,335	73,043		26
27	Other (specify):*			56,149	56,149		56,149	(56,149)			27
28	TOTAL General Administration	278,130	26,837	1,087,105	1,392,072	(60,773)	1,331,299	(6,387)	1,324,912		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,645,031	871,835	2,330,908	5,847,774	(395,900)	5,451,874	207,720	5,659,594		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-Bloomington

#0048157

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01/01/08

Ending:

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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							173,468	173,468			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,582	16,582		16,582	132,818	149,400			32
33	Real Estate Taxes							75,436	75,436			33
34	Rent-Facility & Grounds			486,180	486,180		486,180	(481,031)	5,149			34
35	Rent-Equipment & Vehicles			4,336	4,336		4,336	2,053	6,389			35
36	Other (specify):*											36
37	TOTAL Ownership			507,098	507,098		507,098	(97,256)	409,842			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					335,127	335,127		335,127			39
40	Barber and Beauty Shops			5,765	5,765		5,765		5,765			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,773	60,773		60,773			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			5,765	5,765	395,900	401,665		401,665			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,645,031	871,835	2,843,771	6,360,637		6,360,637	110,464	6,471,101			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-Bloomington

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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	(6,890)	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	(3,566)	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)	(5,161)	23		16
17	Non-Care Related Fees	(528)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,837)	24		19
20	Contributions	(149)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,840)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(56,000)	27		24
25	Fund Raising, Advertising and Promotional	(8,910)	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)	\$ (100,881)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	211,345		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 211,345		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 110,464		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Bloomington

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		(6,890)	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16		(5,161)	23
17		(528)	20
18			18
19			24
20		(149)	27
21			21
22		(7,840)	19
23			23
24		(56,000)	27
25		(8,910)	20
26			26
27			27
28			28
29		0	33
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(85,478)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Bloomington

0048157

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	6,110	0	0	0	0	0	0	0	0	6,110	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	23	0	0	0	0	0	0	0	0	23	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,150	0	0	0	0	0	0	0	0	2,150	5
6	Maintenance	0	0	15,301	0	0	0	0	0	0	0	0	15,301	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	23,584	0	0	0	0	0	0	0	0	23,584	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,494	0	0	0	0	0	0	0	0	2,494	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	185,153	0	0	0	0	0	0	0	0	0	185,153	10a
11	Activities	0	0	1,606	0	0	0	0	0	0	0	0	1,606	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,270	0	0	0	0	0	0	0	0	1,270	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	185,153	5,370	0	0	0	0	0	0	0	0	190,523	16
	C. General Administration													
17	Administrative	0	0	77,366	0	0	0	0	0	0	0	0	77,366	17
18	Directors Fees	0	0	8,241	0	0	0	0	0	0	0	0	8,241	18
19	Professional Services	(7,840)	(250,708)	8,396	0	0	0	0	0	0	0	0	(250,152)	19
20	Fees, Subscriptions & Promotions	(9,438)	0	7,470	0	0	0	0	0	0	0	0	(1,968)	20
21	Clerical & General Office Expenses	0	0	173,595	0	0	0	0	0	0	0	0	173,595	21
22	Employee Benefits & Payroll Taxes	0	0	35,477	0	0	0	0	0	0	0	0	35,477	22
23	Inservice Training & Education	(5,161)	0	758	0	0	0	0	0	0	0	0	(4,403)	23
24	Travel and Seminar	(11,837)	0	11,108	0	0	0	0	0	0	0	0	(729)	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	12,335	0	0	0	0	0	0	0	0	12,335	26
27	Other (specify):*	(56,149)	0	0	0	0	0	0	0	0	0	0	(56,149)	27
28	TOTAL General Administration	(90,425)	(250,708)	334,746	0	0	0	0	0	0	0	0	(6,387)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(90,425)	(65,555)	363,700	0	0	0	0	0	0	0	0	207,720	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Bloomington

0048157

Report Period Beginning:

01/01/08 Ending:

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	161,607	0	11,861	0	0	0	0	0	0	0	173,468	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,566)	129,247	0	7,137	0	0	0	0	0	0	0	132,818	32
33	Real Estate Taxes	0	75,436	0	0	0	0	0	0	0	0	0	75,436	33
34	Rent-Facility & Grounds	(6,890)	(486,180)	0	12,039	0	0	0	0	0	0	0	(481,031)	34
35	Rent-Equipment & Vehicles	0	0	0	2,053	0	0	0	0	0	0	0	2,053	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,456)	(119,890)	0	33,090	0	(97,256)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(100,881)	(185,445)	363,700	33,090	0	110,464	45						

Facility Name & ID Number Heritage Manor-Bloomington

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V		\$			\$	\$
2	V	10a	Adjustment for Related Organization	GreenTree Pharmacy	0.00%	185,153	185,153
3	V						
4	V	19	Adjustment for Related Organization	Heritage Operations Group, LLC	0.00%		(250,708)
5	V						
6	V	34	Adjustment for Related Organization	Heritage Manor Real Estate, LLC	0.00%		(486,180)
7	V	33	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		75,436	75,436
8	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		122,424	122,424
9	V	30	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		161,607	161,607
10	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		6,823	6,823
11	V						
12	V						
13	V						
14	Total		\$ 736,888			\$ 551,443	\$ * (185,445)

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

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VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$ 6,110	\$ 6,110	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				23	23	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				2,150	2,150	19
20	V	6 Maintenance				15,301	15,301	20
21	V	7 Other				0		21
22	V	9 Medical Director				2,494	2,494	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,606	1,606	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				1,270	1,270	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				77,366	77,366	29
30	V	18 Directors Fees				8,241	8,241	30
31	V	19 Professional Services				8,396	8,396	31
32	V	20 Fees, Subscription, Promotions				7,470	7,470	32
33	V	21 Clerical & General Office Expenses				173,595	173,595	33
34	V	22 Employee Benefits & Payroll Taxes				35,477	35,477	34
35	V	23 Inservice Training & Education				758	758	35
36	V	24 Travel and Seminar				11,108	11,108	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				12,335	12,335	38
39	Total		\$			\$ 363,700	\$ * 363,700	39

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

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0048157

Report Period Beginning: 01/01/08

Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	27 Other	\$		0.00%	\$ 0	\$	15	
16	V	30 Depreciation				11,861	11,861	16	
17	V	31 Amortization of Pre-Op & Org				0		17	
18	V	32 Interest				7,137	7,137	18	
19	V	33 Real Estate Taxes				0		19	
20	V	34 Rent-Facility & Grounds				12,039	12,039	20	
21	V	35 Rent-Equipment & Vehicles				2,053	2,053	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		\$			\$ 33,090	\$ *	33,090	39

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

Facility Name & ID Number Heritage Manor-Bloomington # 0048157 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					\$ 8,241	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	\$ 8,241		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-Bloomington

0048157

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 144,981	\$ 144,706	111	\$ 6,110	1
2	2	Food Purchase	Beds	2,634	25	0	0	111	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	111	23	3
4	4	Laundry	Beds	2,634	25	0	0	111	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	111	2,150	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	111	15,301	6
7	7	Other	Beds	2,634	25	0	0	111	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	111	2,494	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	111	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	111	1,606	10
11	12	Social Service	Beds	2,634	25	0	0	111	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	111	1,270	12
13	14	Program Transportation	Beds	2,634	25	0	0	111	0	13
14	15	Other	Beds	2,634	25	0	0	111	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	111	77,366	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	111	8,241	16
17	19	Professional Services	Beds	2,634	25	199,226	0	111	8,396	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	111	7,470	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	111	173,595	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	111	35,477	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	111	758	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	111	11,108	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	111	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	111	12,335	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 363,700	25

Facility Name & ID Number Heritage Manor-Bloomington

0048157

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	111	\$	111	\$	1
2	30	Depreciation	Beds	2,634	111	281,453	111	11,861	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	111		111		3
4	32	Interest	Beds	2,634	111	169,367	111	7,137	4
5	33	Real Estate Taxes	Beds	2,634	111		111		5
6	34	Rent-Facility & Grounds	Beds	2,634	111	285,687	111	12,039	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	111	48,715	111	2,053	7
8	36	Other	Beds	2,634	111		111		8
9	38	Medically Nec Transportation	Beds	2,634	111		111		9
10	39	Ancillary Service Centers	Beds	2,634	111		111		10
11	40	Barber and Beauty Shops	Beds	2,634	111		111		11
12	41	Coffee and Gift Shops	Beds	2,634	111		111		12
13	42	Other	Beds	2,634	111		111		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 785,222	\$	\$ 33,090	25

Facility Name & ID Number

Heritage Manor-Bloomington

0048157

Report Period Beginning:

01/01/08

Ending:

12/31/08

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			\$	\$ 1,775,044	03/11	variable	\$ 122,424	1
2	Bank of America		xx	Loan Fees							6,823	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							16,582	6
7												7
8												8
9	TOTAL Facility Related						\$	\$ 1,775,044			\$ 145,829	9
	B. Non-Facility Related*											
10	Interest Income										(3,566)	10
11	Allocated Corporate										7,137	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 3,571	14
15	TOTALS (line 9+line14)						\$	\$ 1,775,044			\$ 149,400	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line # _____* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)			\$ 75,436	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 75,436	3
4. Real Estate Tax accrual used for 2008 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.			\$ 75,436	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	71,352	8		
2004	69,768	9		
2005	76,294	10		
2006	76,940	11		
2007	75,436	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

Facility Name & ID Number Heritage Manor-Bloomington

0048157 Report Period Beginning:

01/01/08 Ending:

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,183 B. General Construction Type: Exterior brick Frame wood Number of Stories _____

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>116,576</u>	1
2					2
3	TOTALS			\$ <u>116,576</u>	3

Facility Name & ID Number Heritage Manor-Bloomington

0048157

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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	111				\$ 560,548	\$		\$	\$	\$	4
5					221,147						5
6											6
7											7
8											8
	Improvement Type**										
9	1978 Improvements		1978		14,607						9
10	1979 Improvements		1979		95,460						10
11	1980 Improvements		1980		75,591						11
12	1981 Improvements		1981		11,544						12
13	1982 Improvements		1982		9,256						13
14	1983 Improvements		1983		13,130						14
15	1984 Improvements		1984		7,215						15
16	1985 Improvements		1985		45,885						16
17	1986 Improvements		1986		13,469						17
18	1988 Improvements		1988		83,109						18
19	1989 Improvements		1989		2,439						19
20	1990 Improvements		1990		30,676						20
21	1991 Improvements		1991		4,207						21
22	1992 Improvements		1992		1,208						22
23	1993 Improvements		1993		97,303						23
24	1994 Improvements		1994		29,638						24
25	1995 Improvements		1995		121,304						25
26	BOILER		1996		17,850						26
27	EXHAUST HOOD		1996		1,075						27
28	CODE ALERT		1996		1,852						28
29	PHONE SYSTEM		1996		2,339						29
30	INTERIOR REMODEL		1996		103,103						30
31											31
32											32
33											33
34	C/O Allocation							11,861	11,861		34
35	Book Depreciation					130,757		130,757		1,589,749	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Bloomington

0048157

Report Period Beginning:

01/01/08

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12/31/08

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Interior Rehab--paint, wallpaper, remodel facility	1997	\$ 211,945	\$		\$	\$	\$	37
38	Remodel Physical Therapy	1997	43,069						38
39	Disposal Unit--Kitchen	1997	1,439						39
40	Code Alert System	1997	1,997						40
41	Kitchen Remodel	1997	766						41
42									42
43	Code Alert/Nurse Call System	1998	3,654						43
44	Kitchen Remodel	1998	4,166						44
45	Remodel Physical Therapy	1998	1,813						45
46	Addition--Materials	1998	13,431						46
47	Addition--Professional Fees	1998	109,885						47
48									48
49	Addition--Materials	1999	1,155,066						49
50	Addition--Professional Fees	1999	22,035						50
51	Steam Table Hood	1999	3,821						51
52	ALTA Survey	1999	2,434						52
53	Dish Washing Area	1999	4,083						53
54	Sewage Pump	1999	2,492						54
55	Parking Lot Pavement	1999	6,743						55
56									56
57	Dayroom Light Fixtures	2000	6,189						57
58	Door Kickplates	2000	2,991						58
59	Storm windows	2000	4,011						59
60	Addition--Materials	2000	12,770						60
61	Addition--Professional Fees	2000	5,893						61
62	Roof Repair	2000	5,510						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,190,158	\$ 130,757		\$ 142,618	\$ 11,861	\$ 1,589,749	70

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

Facility Name & ID Number Heritage Manor-Bloomington

0048157

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,190,158	\$ 130,757		\$ 142,618	\$ 11,861	\$ 1,589,749	1
2	Paging System	2001	2,456						2
3	Alarm Door/Lock	2001	1,950						3
4	Code Alert	2001	3,965						4
5	Electrical Wiring for A/C Unit	2001	1,805						5
6	Main Water Meter	2001	2,000						6
7	Valves Boiler Unit	2001	1,883						7
8									8
9	Smoke Detectors and Installation	2002	14,551						9
10	Mixing valve	2002	1,862						10
11	Main Corridor Rehab (Wallcovering)	2002	3,885						11
12	Floor Tile	2002	1,280						12
13	Kitchen	2002	957						13
14	Roof Repair	2002	5,283						14
15									15
16	Smoke Detectors and Installation	2003	5,970						16
17	Roof Replacement	2003	111,250						17
18	Sprinklers	2003	31,119						18
19	Parking Lot	2003	3,862						19
20	Ceramic Tile	2003	1,315						20
21	Compressor	2003	3,898						21
22	Wallpaper	2003	857						22
23	Maglock Keypad	2003	2,762						23
24	ANSUL Fire Suppression	2003	1,450						24
25	Fire Escape Remodel	2003	2,003						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,396,521	\$ 130,757		\$ 142,618	\$ 11,861	\$ 1,589,749	34

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

Facility Name & ID Number Heritage Manor-Bloomington

0048157

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,396,521	\$ 130,757		\$ 142,618	\$ 11,861	\$ 1,589,749	1
2	Sewage Pump	2004	3,823						2
3	Nurses Station A/C	2004	1,478						3
4	Fire Alarm	2004	2,825						4
5	Sealcoat Parking Lot	2004	1,646						5
6	Storm Windows	2004	645						6
7	Window A/C (8)	2004	6,030						7
8	Ceiling Repairs	2004	4,011						8
9									9
10	Delayed Egress Latches	2005	12,431						10
11	Mixing valve	2005	1,360						11
12	Paint ceiling	2005	596						12
13	A/C	2005	2,153						13
14	Sidewalk	2005	2,100						14
15									15
16	Plumbing	2006	6,791						16
17	A/C -- Thru wall units	2006	6,900						17
18	Exterior Painting	2006	11,650						18
19	Compressor	2006	5,015						19
20	Condensing Unit	2006	4,902						20
21	Insinkerator	2006	2,350						21
22	Water Softener	2006	27,469						22
23	Basement De-watering	2006	3,750						23
24	Paint Kitchen	2006	1,820						24
25	Repair building	2006	1,199						25
26	Landscaping	2006	1,335						26
27	Pump Motor	2006	1,072						27
28	Mixing valve	2006	2,884						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,512,756	\$ 130,757		\$ 142,618	\$ 11,861	\$ 1,589,749	34

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

Facility Name & ID Number Heritage Manor-Bloomington

0048157

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,512,756	\$ 130,757		\$ 142,618	\$ 11,861	\$ 1,589,749	1
2	Resident Rooms Remodel -- Paint and flooring	2007	13,957						2
3	Sprinkler	2007	1,152						3
4	Compressor	2007	4,006						4
5	Condensor	2007	2,250						5
6	Water Heater	2007	7,359						6
7	Therapy Room Remodel-- Paint & Flooring	2007	2,527						7
8	Window treatments	2007	583						8
9	Cooler	2007	642						9
10	Boiler	2007	4,803						10
11									11
12	Heat/Cool Units	2008	5,420						12
13	Replace Fire Escape	2008	13,577						13
14	Remodel Facility - Professional Fees	2008	26,038						14
15	Water Heater --Backflow	2008	4,926						15
16	Fire Alarm	2008	63,563						16
17	Water Heater	2008	6,057						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)		\$ 3,669,616	\$ 130,757		\$ 142,618	\$ 11,861	\$ 1,589,749	34

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

Facility Name & ID Number Heritage Manor-Bloomington # 0048157 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,138,982	\$ 30,850	\$ 30,850	\$		\$ 1,012,846	71
72	Current Year Purchases	23,753						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,162,735	\$ 30,850	\$ 30,850	\$		\$ 1,012,846	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)	\$ 4,948,927	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 161,607	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 173,468	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,861	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,602,595	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-Bloomington

0048157

Report Period Beginning: 01/01/08

Ending: 12/31/08

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

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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 4,336 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		3,907		3,907
3	Classroom Wages (a)				
4	Clinical Wages (b)		11,592		11,592
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 15,499	\$	\$ 15,499
10	SUM OF line 9, col. 1 and 2 (e)	\$	15,499		

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 279,843	\$		\$ 279,843	1
2	Licensed Speech and Language Development Therapist		hrs			34,554			34,554	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			361,020	242		361,262	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				321,230		321,230	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					13,897			13,897	13
14	TOTAL			\$		\$ 689,314	\$ 321,472		\$ 1,010,786	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-Bloomington# 0048157Report Period Beginning: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,891	\$	1
2	Cash-Patient Deposits	12,866		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	982,743		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,273		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,389,068)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (364,295)	\$	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)	\$ (364,295)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 298,118	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,866		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	277,018		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,700		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	<u>IPA Tax</u>	15,319		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 607,021	\$	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)	\$ 607,021	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (971,316)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (364,295)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (619,524)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (619,524)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(351,792)	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)	\$ (351,792)	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)	\$ (971,316)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Bloomington# 0048157Report Period Beginning: 01/01/08Ending: 12/31/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,586,788	1
2	Discounts and Allowances for all Levels	(2,346,166)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,240,622	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,231,641	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,231,641	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	224	12
13	Barber and Beauty Care	10,104	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,890	16
17	Sale of Drugs	515,738	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	60	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 533,016	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,566	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,566	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,008,845	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,058,675	31
32	Health Care	3,397,027	32
33	General Administration	1,392,072	33
B. Capital Expense			
34	Ownership	507,098	34
C. Ancillary Expense			
35	Special Cost Centers	5,765	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,360,637	40
41	Income before Income Taxes (line 30 minus line 40)**	(351,792)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (351,792)	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-Bloomington

0048157

Report Period Beginning: 01/01/08

Ending:

12/31/08

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,860	2,080	\$ 57,289	\$ 27.54	1
2	Assistant Director of Nursing	1,824	2,080	49,156	23.63	2
3	Registered Nurses	6,564	6,845	205,422	30.01	3
4	Licensed Practical Nurses	19,225	21,265	480,107	22.58	4
5	CNAs & Orderlies	66,379	69,759	863,989	12.39	5
6	CNA Trainees	1,200	1,200	11,592	9.66	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,027	3,458	55,892	16.16	8
9	Activity Director					9
10	Activity Assistants	6,974	7,493	73,068	9.75	10
11	Social Service Workers	3,001	3,121	46,105	14.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,120	24,420	260,031	10.65	15
16	Dishwashers					16
17	Maintenance Workers	7,885	8,564	103,183	12.05	17
18	Housekeepers	9,643	9,972	85,373	8.56	18
19	Laundry	7,475	7,922	75,694	9.55	19
20	Administrator			67,356		20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,220	14,705	210,774	14.33	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)	171,397	182,884	\$ 2,645,031 *	\$ 14.46	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		14,200		36
37	Medical Records Consultant		1,594		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,330		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		2,627		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,751		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,333	\$ 53,322		50
51	Licensed Practical Nurses	5,581	195,346		51
52	Certified Nurse Assistants/Aides	2,778	69,444		52
53	TOTAL (lines 50 - 52)	9,692	\$ 318,112		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES x NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Heritage Manor Bloomington 38349 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,773
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. \$ 1,331
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
- g. Does the facility transport residents to and from day training? no**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. Not available at this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

