



Facility Name & ID Number Heritage Manor-Normal# 0048082 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>164</u>	Skilled (SNF)	<u>164</u>	<u>59,860</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>164</u>	TOTALS	<u>164</u>	<u>59,860</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>24,694</u>	<u>21,224</u>	<u>4,532</u>	<u>50,450</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>24,694</u>	<u>21,224</u>	<u>4,532</u>	<u>50,450</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.28%

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 &amp; 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 4,532Medicare 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-Normal # 0048082 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	
	<b>A. General Services</b>											
1	Dietary	440,660	25,123		465,783		465,783	9,027	474,810			1
2	Food Purchase		276,616		276,616		276,616		276,616			2
3	Housekeeping	206,505	47,806		254,311		254,311	33	254,344			3
4	Laundry	120,881	22,824		143,705		143,705		143,705			4
5	Heat and Other Utilities			181,284	181,284		181,284	3,177	184,461			5
6	Maintenance	157,103	90,165	72,037	319,305		319,305	22,607	341,912			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	925,149	462,534	253,321	1,641,004		1,641,004	34,844	1,675,848			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			9,600	9,600		9,600	3,686	13,286			9
10	Nursing and Medical Records	2,771,751	162,358	9,251	2,943,360		2,943,360		2,943,360			10
10a	Therapy		478,269	556,475	1,034,744	(492,169)	542,575	121,909	664,484			10a
11	Activities	140,962	3,509		144,471		144,471	2,373	146,844			11
12	Social Services	36,320		4,410	40,730		40,730		40,730			12
13	CNA Training	22,567	5,407		27,974		27,974	1,876	29,850			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,971,600	649,543	579,736	4,200,879	(492,169)	3,708,710	129,844	3,838,554			16
	<b>C. General Administration</b>											
17	Administrative	79,382			79,382		79,382	114,307	193,689			17
18	Directors Fees							12,176	12,176			18
19	Professional Services			401,173	401,173		401,173	(388,769)	12,404			19
20	Dues, Fees, Subscriptions & Promotions			132,143	132,143	(89,790)	42,353	(360)	41,993			20
21	Clerical & General Office Expenses	300,754	30,600	10,722	342,076		342,076	256,483	598,559			21
22	Employee Benefits & Payroll Taxes			845,746	845,746		845,746	52,416	898,162			22
23	Inservice Training & Education			5,460	5,460		5,460	(3,461)	1,999			23
24	Travel and Seminar			5,457	5,457		5,457	(3,458)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			87,856	87,856		87,856	18,225	106,081			26
27	Other (specify):*			37,307	37,307		37,307	(36,965)	342			27
28	<b>TOTAL General Administration</b>	380,136	30,600	1,525,864	1,936,600	(89,790)	1,846,810	20,594	1,867,404			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,276,885	1,142,677	2,358,921	7,778,483	(581,959)	7,196,524	185,282	7,381,806			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-Normal #0048082 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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	
	<b>D. Ownership</b>											
30	Depreciation							299,823	299,823			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,521	24,521		24,521	298,668	323,189			32
33	Real Estate Taxes							103,961	103,961			33
34	Rent-Facility & Grounds			718,320	718,320		718,320	(700,532)	17,788			34
35	Rent-Equipment & Vehicles			9,974	9,974		9,974	3,033	13,007			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			752,815	752,815		752,815	4,953	757,768			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers						492,169	492,169	492,169			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee						89,790	89,790	89,790			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>						581,959	581,959	581,959			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,276,885	1,142,677	3,111,736	8,531,298		8,531,298	190,235	8,721,533			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-Normal

# 0048082

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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	(5,490)	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)	(4,580)	23		16
17	Non-Care Related Fees	(787)	20		17
18	Fines and Penalties				18
19	Entertainment	(19,870)	24		19
20	Contributions	35	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,079)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,000)	27		24
25	Fund Raising, Advertising and Promotional	(10,609)	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		33		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (80,380)		\$	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)	270,615		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 270,615		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ 190,235		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Normal

ID# 0048082

Report Period Beginning: 01/01/08

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16		(4,580)	23
17		(787)	20
18			18
19			24
20		35	27
21			21
22		(2,079)	19
23			23
24		(37,000)	27
25		(10,609)	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	<b>Total</b>	(55,020)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Normal

# 0048082

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	9,027	0	0	0	0	0	0	0	0	9,027	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	33	0	0	0	0	0	0	0	0	33	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,177	0	0	0	0	0	0	0	0	3,177	5
6	Maintenance	0	0	22,607	0	0	0	0	0	0	0	0	22,607	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	34,844	0	0	0	0	0	0	0	0	34,844	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	3,686	0	0	0	0	0	0	0	0	3,686	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	121,909	0	0	0	0	0	0	0	0	0	121,909	10a
11	Activities	0	0	2,373	0	0	0	0	0	0	0	0	2,373	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,876	0	0	0	0	0	0	0	0	1,876	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	<b>TOTAL Health Care and Programs</b>	0	121,909	7,935	0	0	0	0	0	0	0	0	129,844	16
	<b>C. General Administration</b>													
17	Administrative	0	0	114,307	0	0	0	0	0	0	0	0	114,307	17
18	Directors Fees	0	0	12,176	0	0	0	0	0	0	0	0	12,176	18
19	Professional Services	(2,079)	(399,094)	12,404	0	0	0	0	0	0	0	0	(388,769)	19
20	Fees, Subscriptions & Promotions	(11,396)	0	11,036	0	0	0	0	0	0	0	0	(360)	20
21	Clerical & General Office Expenses	0	0	256,483	0	0	0	0	0	0	0	0	256,483	21
22	Employee Benefits & Payroll Taxes	0	0	52,416	0	0	0	0	0	0	0	0	52,416	22
23	Inservice Training & Education	(4,580)	0	1,119	0	0	0	0	0	0	0	0	(3,461)	23
24	Travel and Seminar	(19,870)	0	16,412	0	0	0	0	0	0	0	0	(3,458)	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	18,225	0	0	0	0	0	0	0	0	18,225	26
27	Other (specify):*	(36,965)	0	0	0	0	0	0	0	0	0	0	(36,965)	27
28	<b>TOTAL General Administration</b>	(74,890)	(399,094)	494,578	0	0	0	0	0	0	0	0	20,594	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(74,890)	(277,185)	537,357	0	0	0	0	0	0	0	0	185,282	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Normal

# 0048082

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

	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	282,299	0	17,524	0	0	0	0	0	0	0	299,823	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,490)	293,613	0	10,545	0	0	0	0	0	0	0	298,668	32
33	Real Estate Taxes	0	103,961	0	0	0	0	0	0	0	0	0	103,961	33
34	Rent-Facility & Grounds	0	(718,320)	0	17,788	0	0	0	0	0	0	0	(700,532)	34
35	Rent-Equipment & Vehicles	0	0	0	3,033	0	0	0	0	0	0	0	3,033	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(5,490)</b>	<b>(38,447)</b>	<b>0</b>	<b>48,890</b>	<b>0</b>	<b>4,953</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(80,380)</b>	<b>(315,632)</b>	<b>537,357</b>	<b>48,890</b>	<b>0</b>	<b>190,235</b>	<b>45</b>						

Facility Name & ID Number Heritage Manor-Normal

# 0048082

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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		121,909	121,909
3	V						
4	V	19	Adjustment for Related Organization	Heritage Operations Group, LLC	0.00%		(399,094)
5	V						
6	V	34	Adjustment for Related Organization	Heritage Manor Real Estate, LLC	0.00%		(718,320)
7	V	33	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		103,961	103,961
8	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		285,483	285,483
9	V	30	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		282,299	282,299
10	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		8,130	8,130
11	V						
12	V						
13	V						
14	Total		\$ 1,117,414			\$ 801,782	\$ * (315,632)

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

Facility Name & ID Number Heritage Manor-Normal# 0048082Report Period Beginning: 01/01/08Ending: 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	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$ 9,027	\$ 9,027	15	
16	V	2 Food Purchase				0		16	
17	V	3 Housekeeping				33	33	17	
18	V	4 Laundry				0		18	
19	V	5 Heat & Other Utilities				3,177	3,177	19	
20	V	6 Maintenance				22,607	22,607	20	
21	V	7 Other				0		21	
22	V	9 Medical Director				3,686	3,686	22	
23	V	10 Nursing & Medical Records				0		23	
24	V	11 Activities				2,373	2,373	24	
25	V	12 Social Service				0		25	
26	V	13 Nurse Aide Training				1,876	1,876	26	
27	V	14 Program Transportation				0		27	
28	V	15 Other				0		28	
29	V	17 Administrative				114,307	114,307	29	
30	V	18 Directors Fees				12,176	12,176	30	
31	V	19 Professional Services				12,404	12,404	31	
32	V	20 Fees, Subscription, Promotions				11,036	11,036	32	
33	V	21 Clerical & General Office Expenses				256,483	256,483	33	
34	V	22 Employee Benefits & Payroll Taxes				52,416	52,416	34	
35	V	23 Inservice Training & Education				1,119	1,119	35	
36	V	24 Travel and Seminar				16,412	16,412	36	
37	V	25 Other Admin. Staff Transportation				0		37	
38	V	26 Insurance-Prop.Liab.Malpract				18,225	18,225	38	
39	Total		\$			\$ 537,357	\$ *	537,357	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	\$		0.00%	\$ 0			15
16	V	30 Depreciation				17,524		17,524	16
17	V	31 Amortization of Pre-Op & Org				0			17
18	V	32 Interest				10,545		10,545	18
19	V	33 Real Estate Taxes				0			19
20	V	34 Rent-Facility & Grounds				17,788		17,788	20
21	V	35 Rent-Equipment & Vehicles				3,033		3,033	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		\$			\$ 48,890	\$ *	48,890	39

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

Facility Name & ID Number Heritage Manor-Normal # 0048082 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					\$ 12,176	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	\$ 12,176		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-Normal

# 0048082

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	164	\$ 9,027	1
2	2	Food Purchase	Beds	2,634	25	0	0	164	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	164	33	3
4	4	Laundry	Beds	2,634	25	0	0	164	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	164	3,177	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	164	22,607	6
7	7	Other	Beds	2,634	25	0	0	164	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	164	3,686	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	164	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	164	2,373	10
11	12	Social Service	Beds	2,634	25	0	0	164	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	164	1,876	12
13	14	Program Transportation	Beds	2,634	25	0	0	164	0	13
14	15	Other	Beds	2,634	25	0	0	164	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	164	114,307	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	164	12,176	16
17	19	Professional Services	Beds	2,634	25	199,226	0	164	12,404	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	164	11,036	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	164	256,483	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	164	52,416	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	164	1,119	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	164	16,412	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	164	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	164	18,225	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 537,357	25

Facility Name & ID Number Heritage Manor-Normal

# 0048082

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	164	\$	\$	164	\$	1
2	30	Depreciation	Beds	2,634	164	281,453	164	17,524		2
3	31	Amortization of Pre-Op & Org	Beds	2,634	164		164			3
4	32	Interest	Beds	2,634	164	169,367	164	10,545		4
5	33	Real Estate Taxes	Beds	2,634	164		164			5
6	34	Rent-Facility & Grounds	Beds	2,634	164	285,687	164	17,788		6
7	35	Rent-Equipment & Vehicles	Beds	2,634	164	48,715	164	3,033		7
8	36	Other	Beds	2,634	164		164			8
9	38	Medically Nec Transportation	Beds	2,634	164		164			9
10	39	Ancillary Service Centers	Beds	2,634	164		164			10
11	40	Barber and Beauty Shops	Beds	2,634	164		164			11
12	41	Coffee and Gift Shops	Beds	2,634	164		164			12
13	42	Other	Beds	2,634	164		164			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	\$	\$ 48,890		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											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Bank of America		xx	Mortgage			\$	\$ 5,055,511	03/11	variable	\$ 285,483	1								
2	Bank of America		xx	Loan Fees							8,130	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Bank of America		xx	Accounts Receivable							24,521	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$	\$ 5,055,511			\$ 318,134	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(5,490)	10								
11	Allocated Corporate										10,545	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 5,055	14								
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 5,055,511			\$ 323,189	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.		<b>Important</b> , 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.)			\$ <b>103,961</b>	2														
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>103,961</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>103,961</b>	7														
Real Estate Tax History:																		
Real Estate Tax Bill for Calendar Year:																		
2003	<u>82,705</u>	<u>8</u>	<table border="1"> <tr> <td colspan="2"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2007 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		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
<b>FOR BHF USE ONLY</b>																		
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																
2004	<u>90,174</u>	<u>9</u>																
2005	<u>94,949</u>	<u>10</u>																
2006	<u>102,125</u>	<u>11</u>																
2007	<u>103,961</u>	<u>12</u>																

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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor-Normal COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048082

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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-29-227-016</u>	_____	\$ <u>130,854.00</u>	\$ <u>103,961.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>130,854.00</u>	\$ <u>103,961.00</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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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-Normal

# 0048082 Report Period Beginning:

01/01/08 Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 51,164 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>60,687</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>60,687</u>	3

Facility Name & ID Number Heritage Manor-Normal

# 0048082

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	164				\$ 1,860,193	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	1979 Improvements			1979	66,917						9
10	1980 Improvements			1980	48,089						10
11	1981 Improvements			1981	17,747						11
12	1982 Improvements			1982	18,009						12
13	1983 Improvements			1983	19,892						13
14	1984 Improvements			1984	25,484						14
15	1985 Improvements			1985	531,851						15
16	1986 Improvements			1986	82,460						16
17	1987 Improvements			1987	17,447						17
18	1988 Improvements			1988	133,532						18
19	1989 Improvements			1989	39,555						19
20	1990 Improvements			1990	18,557						20
21	1991 Improvements			1991	5,776						21
22	1992 Improvements			1992	8,016						22
23	1993 Improvements			1993	188,048						23
24	1994 Improvements			1994	187,325						24
25	1995 Improvements			1995	10,664						25
26	A/C Basement Laundry			1996	6,741						26
27	Asphalt Repair			1996	21,401						27
28	Remodel/Painting			1996	1,912						28
29	Fire Alarm Repair/Replace			1996	8,069						29
30	Kitchen Floor/Backsplash			1996	1,395						30
31											31
32											32
33											33
34	C/O Allocation							17,524	17,524		34
35	Book Depreciation					260,286		260,286		3,320,152	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 &amp; ID Number Heritage Manor-Normal

# 0048082

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	
37	Tubes--Boiler	1997	\$ 12,279	\$		\$	\$	\$	37
38	Smoke Damper	1997	2,508						38
39	Perimeter Alarm	1997	3,364						39
40	Door Alarm	1997	3,909						40
41	Parking Lot Lights	1997	1,221						41
42	Fire Door	1997	2,146						42
43									43
44	Asbestos Removal	1998	985						44
45	Fire Daper	1998	4,589						45
46	Plumbing Maintenance	1998	3,285						46
47	HVAC Repairs	1998	2,139						47
48	Boiler Retubed	1998	5,720						48
49	Remodel Resident Rooms and Halls-materials	1998	739,117						49
50	Remodel Resident Rooms and Halls- Labor	1998	4,323						50
51	Remodel Resident Rooms and Halls-Professional Fees	1998	38,935						51
52									52
53	Moving Furnature Expense	1998	6,398						53
54	Computer Room Work	1998	896						54
55	Alzheimers Addition-Materials	1998	876,511						55
56	Alzheimers Addition-Labor	1998	516						56
57	Alzheimers Addition-Professional Fees	1998	162,266						57
58	Ventalation System-Materials	1998	54,231						58
59	Ventalation System-Professional Fees	1998	33,010						59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 5,277,428	\$ 260,286		\$ 277,810	\$ 17,524	\$ 3,320,152	70

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

Facility Name &amp; ID Number Heritage Manor-Normal

# 0048082

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,277,428	\$ 260,286		\$ 277,810	\$ 17,524	\$ 3,320,152	1
2	Alzheimers Addition-Materials	1999	1,913,384						2
3	Alzheimers Addition-Labor	1999	16,393						3
4	Alzheimers Addition-Professional Fees	1999	43,955						4
5	Ventilation System-Materials	1999	2,591						5
6	Remodel Resident Rooms--Materials	1999	96,197						6
7	Remodel Resident Rooms--Professional Fees	1999	350						7
8	Patio Replacement	1999	3,700						8
9	WAN Room Renovation	1999	3,230						9
10	ALTA Survey	1999	5,488						10
11	PANIC Hardware	1999	1,941						11
12	Roof Work	1999	4,844						12
13	Boiler Replacement	1999	11,219						13
14	Garage Door	1999	985						14
15	West End Renovations-Labor	1999	2,184						15
16	Assisted Living Professional Fees	1999	1,843						16
17									17
18	West Wing Outlets	2000	8,485						18
19	Alzheimer Unit Flooring	2000	5,631						19
20	Accordian Door and Installation	2000	9,600						20
21	Air conditioning Units (2)	2000	1,240						21
22	Exterior Door Replacement	2000	6,095						22
23	Air conditioner -- Dishroom	2000	12,041						23
24	HVAC temp Control	2000	16,220						24
25	Mop sink and faucet (2)	2000	3,377						25
26	Clinical Sink	2000	847						26
27	Eye Wash Stations	2000	2,566						27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,451,834	\$ 260,286		\$ 277,810	\$ 17,524	\$ 3,320,152	34

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

Facility Name &amp; ID Number Heritage Manor-Normal

# 0048082

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		\$ 7,451,834	\$ 260,286		\$ 277,810	\$ 17,524	\$ 3,320,152	1
2	West End Renovations-Labor	2000	9,940						2
3	West End Renovations-material	2000	7,991						3
4									4
5	Boiler Repair	2001	7,921						5
6	Code Alert	2001	6,248						6
7	Painting & Wallpaper Hallway	2001	2,714						7
8	Condenser	2001	3,203						8
9	Fire System Repair	2001	2,269						9
10	Sign	2001	3,266						10
11	Water Heater	2001	4,797						11
12									12
13	Smoke Detector	2002	2,000						13
14	Fence	2002	2,400						14
15	Mixing Valve	2002	2,000						15
16	Bathroom Repairs	2002	10,179						16
17	Sprinkler System	2002	1,019						17
18	Computer Cable	2002	1,076						18
19	Boiler Pump	2002	5,000						19
20	A/C Unit	2002	2,750						20
21	Administrator Office Remodel	2002	4,534						21
22	Fire System Repair	2002	1,234						22
23	A/C Repair	2002	3,535						23
24	Flag & Flag Pole	2002	600						24
25	Elevator Repairs	2002	6,862						25
26	Code Alert	2002	975						26
27	Exhaust Fan	2002	1,350						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,545,697	\$ 260,286		\$ 277,810	\$ 17,524	\$ 3,320,152	34

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

Facility Name &amp; ID Number Heritage Manor-Normal

# 0048082

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	<b>Totals from Page 12C, Carried Forward</b>		\$ 7,545,697	\$ 260,286		\$ 277,810	\$ 17,524	\$ 3,320,152	1
2	Fire System	2003	8,614						2
3	Flag Pole	2003	490						3
4	Security Door	2003	5,990						4
5	A/C Unit	2003	1,580						5
6	Condensing Unit	2003	1,137						6
7	Compressor	2003	2,067						7
8	Sewage Ejection	2003	17,028						8
9	A/C Unit	2003	1,628						9
10									10
11	Sewage Ejection	2004	12,312						11
12	A/C Unit	2004	1,175						12
13	Water Softener	2004	18,667						13
14	Exterior Referbish	2004	2,202						14
15	Boiler	2004	16,060						15
16									16
17	Boiler	2005	388						17
18	Nurses Station	2005	8,146						18
19	Smoke Detectors	2005	3,884						19
20	Windows	2005	6,146						20
21	Tempering Valve	2005	2,510						21
22	Sewage Ejection	2005	1,310						22
23	Ansul System	2005	2,320						23
24	Accelerator	2005	1,548						24
25	A/C Unit	2005	2,550						25
26	A/C Unit	2005	1,275						26
27	Sidewalk Replacement	2005	21,297						27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 7,686,021	\$ 260,286		\$ 277,810	\$ 17,524	\$ 3,320,152	34

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

Facility Name &amp; ID Number Heritage Manor-Normal

# 0048082

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 12D, Carried Forward		\$ 7,686,021	\$ 260,286		\$ 277,810	\$ 17,524	\$ 3,320,152	1
2	A/C Unit	2006	5,900						2
3	Phone System	2006	1,418						3
4	Door	2006	1,613						4
5									5
6	Interior Door	2007	425						6
7	Generator	2007	16,165						7
8	Mixing valve	2007	1,955						8
9	Water pipe	2007	2,350						9
10	Water Heater	2007	27,451						10
11	Window	2007	906						11
12	AC Condensing Unit	2007	2,345						12
13	Flooring	2007	775						13
14									14
15	Handrails	2008	2,904						15
16	Grinder Pump	2008	2,566						16
17	Exterior Panting	2008	13,372						17
18	Dining Room Windows	2008	8,150						18
19	Dining Room Roof	2008	78,218						19
20	Driveway Improvements	2008	4,400						20
21	boiler	2008	5,680						21
22	Duct Replacement	2008	16,973						22
23	Carpet	2008	54,088						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)		\$ 7,933,675	\$ 260,286		\$ 277,810	\$ 17,524	\$ 3,320,152	34

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

Facility Name & ID Number Heritage Manor-Normal # 0048082 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	\$ 1,201,562	\$ 22,013	\$ 22,013	\$		\$ 1,203,839	71
72	Current Year Purchases	33,004						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,234,566	\$ 22,013	\$ 22,013	\$		\$ 1,203,839	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)	\$ 9,228,928	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 282,299	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 299,823	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,524	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,523,991	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	<b>TOTAL</b>				\$ _____			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	\$ _____ 0
13.	_____ /2010	\$ _____ 0
14.	_____ /2011	\$ _____ 0

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 9,974 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	<b>TOTAL</b>		\$ _____	\$ _____	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		5,407		5,407
3	Classroom Wages (a)				
4	Clinical Wages (b)		22,567		22,567
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 27,974	\$	\$ 27,974
10	SUM OF line 9, col. 1 and 2 (e)	\$	27,974		

**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)	
<b>TOTAL TRAINED</b>	

- (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.

Facility Name & ID Number Heritage Manor-Normal# 0048082

Report Period Beginning:

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12/31/08

## 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	\$		\$ 252,781	\$		\$ 252,781	1
2	Licensed Speech and Language Development Therapist		hrs			3,324			3,324	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			285,943	527		286,470	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				477,742		477,742	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					14,427			14,427	13
14	TOTAL			\$		\$ 556,475	\$ 478,269		\$ 1,034,744	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-Normal # 0048082 Report 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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 16,445	\$	1
2	Cash-Patient Deposits	13,881		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,097,689		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,234		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(366,339)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 782,910	\$	10
	<b>B. Long-Term Assets</b>			
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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 782,910	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 260,107	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,881		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	428,902		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,736		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>IPA Tax</u>	22,632		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 730,258	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 730,258	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 52,652	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 782,910	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (253,195)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (253,195)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	305,847	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)	\$ 305,847	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 52,652	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Normal# 0048082Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,411,267	1
2	Discounts and Allowances for all Levels	(2,154,165)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,257,102</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,784,246	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,784,246</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	26,006	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,214	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	763,264	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 791,484</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	(1,177)	24
25	Interest and Other Investment Income***	5,490	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 4,313</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 8,837,145</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,641,004	31
32	Health Care	4,200,879	32
33	General Administration	1,936,600	33
<b>B. Capital Expense</b>			
34	Ownership	752,815	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 8,531,298</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>305,847</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 305,847</b>	<b>43</b>

\* 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-Normal

# 0048082

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	1,912	2,080	\$ 59,501	\$ 28.61	1
2	Assistant Director of Nursing	1,976	2,080	55,209	26.54	2
3	Registered Nurses	12,157	13,079	362,432	27.71	3
4	Licensed Practical Nurses	30,245	32,587	694,224	21.30	4
5	CNAs & Orderlies	120,887	128,579	1,537,063	11.95	5
6	CNA Trainees	2,000		22,567		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,000	4,233	63,322	14.96	8
9	Activity Director					9
10	Activity Assistants	13,598	14,238	140,962	9.90	10
11	Social Service Workers	2,193	2,412	36,320	15.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	44,272	47,238	440,660	9.33	15
16	Dishwashers					16
17	Maintenance Workers	13,753	14,944	157,103	10.51	17
18	Housekeepers	23,263	24,367	206,505	8.47	18
19	Laundry	12,346	13,117	120,881	9.22	19
20	Administrator			79,382		20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,497	18,209	300,754	16.52	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	<b>TOTAL (lines 1 - 33)</b>	<b>298,099</b>	<b>317,163</b>	<b>\$ 4,276,885 *</b>	<b>\$ 13.48</b>	<b>34</b>

\* 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	9,600		36
37	Medical Records Consultant	1,133		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,920		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	4,410		45
46	Other(specify)			46
47				47
48				48
49	<b>TOTAL (lines 35 - 48)</b>	<b>\$ 20,063</b>		<b>49</b>

**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	<b>TOTAL (lines 50 - 52)</b>	<b>\$</b>		<b>53</b>





Facility Name &amp; ID Number Heritage Manor-Normal

**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 Normal 38281 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 89,790  
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. \$ 31,340
- (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.



