



Facility Name & ID Number Heritage Manor-Bloomington

# 0048157 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>23,007</u>	<u>7,147</u>	<u>3,203</u>	<u>33,357</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>23,007</u>	<u>7,147</u>	<u>3,203</u>	<u>33,357</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.33%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

none

F. Does the facility maintain a daily midnight census?

yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 07/2006

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

YES  Date \_\_\_\_\_ NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 3,203

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Manor-Bloomington # 0048157 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	291,211	38,045		329,256		329,256	4,328	333,584		1
2	Food Purchase		183,371		183,371		183,371	1	183,372		2
3	Housekeeping	93,590	25,606		119,196		119,196		119,196		3
4	Laundry	79,014	14,230		93,244		93,244		93,244		4
5	Heat and Other Utilities			127,755	127,755		127,755	2,217	129,972		5
6	Maintenance	113,559	65,920	62,576	242,055		242,055	22,100	264,155		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	577,374	327,172	190,331	1,094,877		1,094,877	28,646	1,123,523		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,300	15,300		15,300	2,151	17,451		9
10	Nursing and Medical Records	1,871,018	187,072	136,959	2,195,049		2,195,049		2,195,049		10
10a	Therapy		261,622	700,037	961,659	(273,583)	688,076	270,646	958,722		10a
11	Activities	77,297	3,137		80,434		80,434	963	81,397		11
12	Social Services	54,619	604	1,754	56,977		56,977		56,977		12
13	CNA Training	14,987	4,816		19,803		19,803	1,574	21,377		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,017,921	457,251	854,050	3,329,222	(273,583)	3,055,639	275,334	3,330,973		16
	<b>C. General Administration</b>										
17	Administrative	72,615			72,615		72,615		72,615		17
18	Directors Fees										18
19	Professional Services			269,506	269,506		269,506	(255,932)	13,574		19
20	Dues, Fees, Subscriptions & Promotions			103,313	103,313	(60,773)	42,540	(4,551)	37,989		20
21	Clerical & General Office Expenses	216,616	31,028	15,415	263,059		263,059	272,650	535,709		21
22	Employee Benefits & Payroll Taxes			566,445	566,445		566,445	35,800	602,245		22
23	Inservice Training & Education			6,525	6,525		6,525	1,121	7,646		23
24	Travel and Seminar			4,846	4,846		4,846	10,069	14,915		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			60,091	60,091		60,091	11,962	72,053		26
27	Other (specify):*			55,200	55,200		55,200	(55,200)			27
28	<b>TOTAL General Administration</b>	289,231	31,028	1,081,341	1,401,600	(60,773)	1,340,827	15,919	1,356,746		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,884,526	815,451	2,125,722	5,825,699	(334,356)	5,491,343	319,899	5,811,242		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 &amp; ID Number

Heritage Manor-Bloomington

#0048157

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							194,571	194,571			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,033	13,033		13,033	110,330	123,363			32
33	Real Estate Taxes							72,139	72,139			33
34	Rent-Facility & Grounds			486,180	486,180		486,180	(485,653)	527			34
35	Rent-Equipment & Vehicles			4,498	4,498		4,498	1,829	6,327			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			503,711	503,711		503,711	(106,784)	396,927			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					273,583	273,583		273,583			39
40	Barber and Beauty Shops			95	95		95		95			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,773	60,773		60,773			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			95	95	334,356	334,451		334,451			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,884,526	815,451	2,629,528	6,329,505		6,329,505	213,115	6,542,620			45

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



Heritage Manor-Bloomington

ID# 0048157

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(528)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(17,128)	19	22
23				23
24		(55,200)	27	24
25		(12,858)	20	25
26				26
27				27
28				28
29		0	33	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(85,714)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Bloomington# 0048157

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	4,328	0	0	0	0	0	0	0	0	4,328	1
2	Food Purchase	0	0	1	0	0	0	0	0	0	0	0	1	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,217	0	0	0	0	0	0	0	0	2,217	5
6	Maintenance	0	0	22,100	0	0	0	0	0	0	0	0	22,100	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>28,646</b>	<b>0</b>	<b>28,646</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	2,151	0	0	0	0	0	0	0	0	2,151	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	270,646	0	0	0	0	0	0	0	0	0	270,646	10a
11	Activities	0	0	963	0	0	0	0	0	0	0	0	963	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,574	0	0	0	0	0	0	0	0	1,574	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>	<b>0</b>	<b>270,646</b>	<b>4,688</b>	<b>0</b>	<b>275,334</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,128)	(252,378)	13,574	0	0	0	0	0	0	0	0	(255,932)	19
20	Fees, Subscriptions & Promotions	(13,386)	0	8,835	0	0	0	0	0	0	0	0	(4,551)	20
21	Clerical & General Office Expenses	0	0	272,650	0	0	0	0	0	0	0	0	272,650	21
22	Employee Benefits & Payroll Taxes	0	0	35,800	0	0	0	0	0	0	0	0	35,800	22
23	Inservice Training & Education	0	0	1,121	0	0	0	0	0	0	0	0	1,121	23
24	Travel and Seminar	0	0	10,069	0	0	0	0	0	0	0	0	10,069	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	11,962	0	0	0	0	0	0	0	0	11,962	26
27	Other (specify):*	(55,200)	0	0	0	0	0	0	0	0	0	0	(55,200)	27
28	<b>TOTAL General Administration</b>	<b>(85,714)</b>	<b>(252,378)</b>	<b>354,011</b>	<b>0</b>	<b>15,919</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(85,714)</b>	<b>18,268</b>	<b>387,345</b>	<b>0</b>	<b>319,899</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Bloomington# 0048157

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	184,044	0	10,527	0	0	0	0	0	0	0	194,571	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,413)	119,374	0	369	0	0	0	0	0	0	0	110,330	32
33	Real Estate Taxes	0	72,139	0	0	0	0	0	0	0	0	0	72,139	33
34	Rent-Facility & Grounds	(6,360)	(486,180)	0	6,887	0	0	0	0	0	0	0	(485,653)	34
35	Rent-Equipment & Vehicles	0	0	0	1,829	0	0	0	0	0	0	0	1,829	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(15,773)</b>	<b>(110,623)</b>	<b>0</b>	<b>19,612</b>	<b>0</b>	<b>(106,784)</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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(101,487)	(92,355)	387,345	19,612	0	0	0	0	0	0	0	213,115	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100%	See Attached				

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$		1
2	V	10a Adjustment for Related Organization		GreenTree Pharmacy	0.00%	270,646	270,646	2
3	V							3
4	V	19 Adjustment for Related Organization	252,378	Heritage Operations Group, LLC	0.00%		(252,378)	4
5	V							5
6	V	34 Adjustment for Related Organization	486,180	Heritage Manor Real Estate, LLC	0.00%		(486,180)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		72,139	72,139	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		112,551	112,551	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		184,044	184,044	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		6,823	6,823	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 738,558			\$ 646,203	\$ * (92,355)	14

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

Facility Name & ID Number Heritage Manor-Bloomington# 0048157Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## 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%	\$	\$	4,328	15	
16	V	2 Food Purchase						1	16	
17	V	3 Housekeeping						0	17	
18	V	4 Laundry						0	18	
19	V	5 Heat & Other Utilities						2,217	19	
20	V	6 Maintenance						22,100	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						2,151	22	
23	V	10 Nursing & Medical Records						0	23	
24	V	11 Activities						963	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						1,574	26	
27	V	14 Program Transportation						0	27	
28	V	15 Other						0	28	
29	V	17 Administrative						0	29	
30	V	18 Directors Fees						0	30	
31	V	19 Professional Services						13,574	31	
32	V	20 Fees, Subscription, Promotions						8,835	32	
33	V	21 Clerical & General Office Expenses						272,650	33	
34	V	22 Employee Benefits & Payroll Taxes						35,800	34	
35	V	23 Inservice Training & Education						1,121	35	
36	V	24 Travel and Seminar						10,069	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						11,962	38	
39	Total		\$			\$	0	\$ *	387,345	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	27 Other	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	0	15	
16	V	30 Depreciation						10,527	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						369	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						6,887	20	
21	V	35 Rent-Equipment & Vehicles						1,829	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	<b>Total</b>		\$			\$	0	\$ *	19,612	39

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

Facility Name &amp; ID Number

Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					\$ 0	18/7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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	\$ 102,708	\$ 102,349	111	\$ 4,328	1
2	2	Food Purchase	Beds	2,634	25	29	0	111	1	2
3	3	Housekeeping	Beds	2,634	25	0	0	111	0	3
4	4	Laundry	Beds	2,634	25	0	0	111	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	111	2,217	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	111	22,100	6
7	7	Other	Beds	2,634	25	0	0	111	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	111	2,151	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	111	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	111	963	10
11	12	Social Service	Beds	2,634	25	0	0	111	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	111	1,574	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	0	0	111	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	111	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	111	13,574	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	111	8,835	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	111	272,650	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	111	35,800	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	111	1,121	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	111	10,069	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	283,859	0	111	11,962	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 387,345	25

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	25	\$	111	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	111	10,527	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		111		3
4	32	Interest	Beds	2,634	25	8,747	111	369	4
5	33	Real Estate Taxes	Beds	2,634	25		111		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	111	6,887	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	111	1,829	7
8	36	Other	Beds	2,634	25		111		8
9	38	Medically Nec Transportation	Beds	2,634	25		111		9
10	39	Ancillary Service Centers	Beds	2,634	25		111		10
11	40	Barber and Beauty Shops	Beds	2,634	25		111		11
12	41	Coffee and Gift Shops	Beds	2,634	25		111		12
13	42	Other	Beds	2,634	25		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				\$ 465,371	\$		\$ 19,612	25

Facility Name & ID Number

Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Bank of America		xx	Mortgage			\$	\$ 1,613,754	03/11	variable	\$ 112,551	1							
2	Bank of America		xx	Loan Fees							6,823	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6	Bank of America		xx	Accounts Receivable							13,033	6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$	\$ 1,613,754			\$ 132,407	9							
<b>B. Non-Facility Related*</b>																			
10	Interest Income										(9,413)	10							
11	Allocated Corporate										369	11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (9,044)	14							
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 1,613,754			\$ 123,363	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**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 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>72,139</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>72,139</b>	3
4. Real Estate Tax accrual used for 2009 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>72,139</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>69,768</b>		8
	2005	<b>76,294</b>		9
	2006	<b>76,940</b>		10
	2007	<b>75,436</b>		11
	2008	<b>72,139</b>		12
	<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,183 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

NONE

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

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

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

XI. OWNERSHIP COSTS:

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

Facility Name &amp; ID Number Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	111				\$ 560,548	\$		\$	\$	\$
5					221,147					
6										
7										
8										
	<b>Improvement Type**</b>									
9	1978 Improvements		1978		14,607					
10	1979 Improvements		1979		95,460					
11	1980 Improvements		1980		75,591					
12	1981 Improvements		1981		11,544					
13	1982 Improvements		1982		9,256					
14	1983 Improvements		1983		13,130					
15	1984 Improvements		1984		7,215					
16	1985 Improvements		1985		45,885					
17	1986 Improvements		1986		13,469					
18	1988 Improvements		1988		83,109					
19	1989 Improvements		1989		2,439					
20	1990 Improvements		1990		30,676					
21	1991 Improvements		1991		4,207					
22	1992 Improvements		1992		1,208					
23	1993 Improvements		1993		97,303					
24	1994 Improvements		1994		29,638					
25	1995 Improvements		1995		121,304					
26	BOILER		1996		17,850					
27	EXHAUST HOOD		1996		1,075					
28	CODE ALERT		1996		1,852					
29	PHONE SYSTEM		1996		2,339					
30	INTERIOR REMODEL		1996		103,103					
31										
32										
33										
34	C/O Allocation							10,527	10,527	
35	Book Depreciation					139,317		139,317		1,729,066
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:

01/01/2009 Ending: 12/31/2009

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	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	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,190,158	\$ 139,317		\$ 149,844	\$ 10,527	\$ 1,729,066	70

\*\*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:

01/01/2009 Ending: 12/31/2009

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,190,158	\$ 139,317		\$ 149,844	\$ 10,527	\$ 1,729,066	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 Surpression	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,396,521	\$ 139,317		\$ 149,844	\$ 10,527	\$ 1,729,066	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:

01/01/2009 Ending: 12/31/2009**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,396,521	\$ 139,317		\$ 149,844	\$ 10,527	\$ 1,729,066	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,512,756	\$ 139,317		\$ 149,844	\$ 10,527	\$ 1,729,066	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:

01/01/2009 Ending: 12/31/2009

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,512,756	\$ 139,317		\$ 149,844	\$ 10,527	\$ 1,729,066	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	Schematic Design (Architect Fees) Facility Renovation	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	HVAC Unit	2009	7,035						19
20	Compressor	2009	4,658						20
21	HVAC Renovation: Boilers, ducts, hvac units & labor	2009	360,549						21
22	Windows	2009	148,790						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,190,648	\$ 139,317		\$ 149,844	\$ 10,527	\$ 1,729,066	34

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

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	\$ 1,162,735	\$ 44,727	\$ 44,727	\$		\$	71
72	Current Year Purchases	33,920						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,196,655	\$ 44,727	\$ 44,727	\$		\$	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,503,879	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 184,044	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 194,571	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,527	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,729,066	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

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

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

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

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

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

YES  NO

16. Rental Amount for movable equipment: \$ 4,498 Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		4,816		4,816
3	Classroom Wages (a)				
4	Clinical Wages (b)		14,987		14,987
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 19,803	\$	\$ 19,803
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	19,803		

**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.

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	\$		\$ 281,092	\$		\$ 281,092	1
2	Licensed Speech and Language Development Therapist		hrs			44,228			44,228	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			362,520	236		362,756	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				261,386		261,386	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					12,197			12,197	13
14	<b>TOTAL</b>			\$		\$ 700,037	\$ 261,622		\$ 961,659	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: 01/01/2009Ending: 12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 4,863	\$	1
2	Cash-Patient Deposits	34,493		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	617,965		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,588		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,553,857)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (874,948)	\$	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>	\$ (874,948)	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 177,492	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,493		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	189,296		30
31	Accrued Taxes Payable (excluding real estate taxes)	36,067		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				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 437,348	\$	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>	\$ 437,348	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,312,296)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (874,948)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (967,372)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (967,372)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(344,924)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (344,924)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (1,312,296)	<b>24</b> *

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

Facility Name & ID Number Heritage Manor-Bloomington# 0048157Report Period Beginning: 01/01/2009Ending: 12/31/2009

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,519,094	1
2	Discounts and Allowances for all Levels	(2,194,376)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,324,718	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,208,116	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,208,116	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,336	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,360	16
17	Sale of Drugs	430,358	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	520	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 441,574	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	9,413	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 9,413	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Other</b>	760	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 760	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,984,581	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,094,877	31
32	Health Care	3,329,222	32
33	General Administration	1,401,600	33
<b>B. Capital Expense</b>			
34	Ownership	503,711	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	95	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>	\$ 6,329,505	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(344,924)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (344,924)	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: **01/01/2009**

Ending:

**12/31/2009**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,895	2,160	\$ 57,673	\$ 26.70	1
2	Assistant Director of Nursing	1,900	2,160	51,676	23.92	2
3	Registered Nurses	13,001	13,461	371,552	27.60	3
4	Licensed Practical Nurses	19,145	20,242	442,760	21.87	4
5	CNAs & Orderlies	73,713	77,888	891,498	11.45	5
6	CNA Trainees	1,500	1,500	14,987	9.99	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,748	3,111	55,859	17.96	8
9	Activity Director					9
10	Activity Assistants	7,032	7,387	77,297	10.46	10
11	Social Service Workers	3,890	4,104	54,619	13.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,835	25,812	291,211	11.28	15
16	Dishwashers					16
17	Maintenance Workers	8,405	8,928	113,559	12.72	17
18	Housekeepers	10,603	11,329	93,590	8.26	18
19	Laundry	6,400	6,851	79,014	11.53	19
20	Administrator	1,900	2,080	72,615	34.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,148	14,593	216,616	14.84	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)	190,115	201,606	\$ 2,884,526 *	\$ 14.31	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	15,300		36
37	Medical Records Consultant	1,600		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	1,754		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 21,984		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,794	\$ 71,774	50
51	Licensed Practical Nurses	1,282	44,880	51
52	Certified Nurse Assistants/Aides	113	2,814	52
53	TOTAL (lines 50 - 52)	3,189	\$ 119,468	53





Facility Name & ID Number Heritage Manor-Bloomington# 0048157Report Period Beginning: 01/01/2009Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES x NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (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? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 1,331
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes  
**g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Sulaski & Webb
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.