



Facility Name & ID Number Heritage Manor-Springfield

# 0041699 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	178	Skilled (SNF)	178	64,970	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	178	TOTALS	178	64,970	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	33,454	13,243	10,609	57,306	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	33,454	13,243	10,609	57,306	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.20%

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 1996

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 10,609

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-Springfield # 0041699 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	465,254	39,783		505,037		505,037	6,941	511,978		1
2	Food Purchase		446,272		446,272		446,272	2	446,274		2
3	Housekeeping	249,961	63,029		312,990		312,990		312,990		3
4	Laundry	119,924	46,095		166,019		166,019		166,019		4
5	Heat and Other Utilities			202,272	202,272		202,272	3,555	205,827		5
6	Maintenance	186,803	118,942	110,156	415,901		415,901	35,440	451,341		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,021,942	714,121	312,428	2,048,491		2,048,491	45,938	2,094,429		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,900	18,900		18,900	3,450	22,350		9
10	Nursing and Medical Records	3,627,730	390,902	18,808	4,037,440		4,037,440		4,037,440		10
10a	Therapy		813,405	720,778	1,534,183	(867,086)	667,097	234,830	901,927		10a
11	Activities	106,479	5,550		112,029		112,029	1,545	113,574		11
12	Social Services	123,312		2,920	126,232		126,232		126,232		12
13	CNA Training							2,525	2,525		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,857,521	1,209,857	761,406	5,828,784	(867,086)	4,961,698	242,350	5,204,048		16
	<b>C. General Administration</b>										
17	Administrative	84,696			84,696		84,696		84,696		17
18	Directors Fees										18
19	Professional Services			451,504	451,504		451,504	(415,836)	35,668		19
20	Dues, Fees, Subscriptions & Promotions			130,681	130,681	(97,455)	33,226	5,654	38,880		20
21	Clerical & General Office Expenses	412,539	59,788	37,181	509,508		509,508	437,222	946,730		21
22	Employee Benefits & Payroll Taxes			1,053,561	1,053,561		1,053,561	57,409	1,110,970		22
23	Inservice Training & Education			6,435	6,435		6,435	1,798	8,233		23
24	Travel and Seminar			7,669	7,669		7,669	16,146	23,815		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			198,341	198,341		198,341	19,183	217,524		26
27	Other (specify):*			102,000	102,000		102,000	(102,000)			27
28	<b>TOTAL General Administration</b>	497,235	59,788	1,987,372	2,544,395	(97,455)	2,446,940	19,576	2,466,516		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,376,698	1,983,766	3,061,206	10,421,670	(964,541)	9,457,129	307,864	9,764,993		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-Springfield

#0041699

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			287,664	287,664		287,664	16,880	304,544			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			137,150	137,150		137,150	(11,879)	125,271			32
33	Real Estate Taxes			130,175	130,175		130,175		130,175			33
34	Rent-Facility & Grounds							11,044	11,044			34
35	Rent-Equipment & Vehicles			7,276	7,276		7,276	2,933	10,209			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			562,265	562,265		562,265	18,978	581,243			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					867,086	867,086		867,086			39
40	Barber and Beauty Shops			12,048	12,048		12,048		12,048			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					97,455	97,455		97,455			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			12,048	12,048	964,541	976,589		976,589			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,376,698	1,983,766	3,635,519	10,995,983		10,995,983	326,842	11,322,825			45

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



Heritage Manor-Springfield

ID# 0041699

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		(1,359)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(40,824)	19	22
23				23
24		(102,000)	27	24
25		(7,155)	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>	<b>(151,338)</b>		<b>49</b>

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Springfield# 0041699

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	6,941	0	0	0	0	0	0	0	0	6,941	1
2	Food Purchase	0	0	2	0	0	0	0	0	0	0	0	2	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	3,555	0	0	0	0	0	0	0	0	3,555	5
6	Maintenance	0	0	35,440	0	0	0	0	0	0	0	0	35,440	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>45,938</b>	<b>0</b>	<b>45,938</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	3,450	0	0	0	0	0	0	0	0	3,450	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	234,830	0	0	0	0	0	0	0	0	0	234,830	10a
11	Activities	0	0	1,545	0	0	0	0	0	0	0	0	1,545	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	2,525	0	0	0	0	0	0	0	0	2,525	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>234,830</b>	<b>7,520</b>	<b>0</b>	<b>242,350</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	(40,824)	(396,780)	21,768	0	0	0	0	0	0	0	0	(415,836)	19
20	Fees, Subscriptions & Promotions	(8,514)	0	14,168	0	0	0	0	0	0	0	0	5,654	20
21	Clerical & General Office Expenses	0	0	437,222	0	0	0	0	0	0	0	0	437,222	21
22	Employee Benefits & Payroll Taxes	0	0	57,409	0	0	0	0	0	0	0	0	57,409	22
23	Inservice Training & Education	0	0	1,798	0	0	0	0	0	0	0	0	1,798	23
24	Travel and Seminar	0	0	16,146	0	0	0	0	0	0	0	0	16,146	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	19,183	0	0	0	0	0	0	0	0	19,183	26
27	Other (specify):*	(102,000)	0	0	0	0	0	0	0	0	0	0	(102,000)	27
28	<b>TOTAL General Administration</b>	<b>(151,338)</b>	<b>(396,780)</b>	<b>567,694</b>	<b>0</b>	<b>19,576</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(151,338)</b>	<b>(161,950)</b>	<b>621,152</b>	<b>0</b>	<b>307,864</b>	<b>29</b>							

## STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Springfield# 0041699

Report Period Beginning:

01/01/2009 Ending:

Summary B

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	0	0	16,880	0	0	0	0	0	0	0	16,880	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,470)	0	0	591	0	0	0	0	0	0	0	(11,879)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	11,044	0	0	0	0	0	0	0	11,044	34
35	Rent-Equipment & Vehicles	0	0	0	2,933	0	0	0	0	0	0	0	2,933	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(12,470)</b>	<b>0</b>	<b>0</b>	<b>31,448</b>	<b>0</b>	<b>18,978</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)	(163,808)	(161,950)	621,152	31,448	0	0	0	0	0	0	0	326,842	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.	50	See Attached				
Memorial Health Ventures	50					

**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%	234,830	234,830	2
3	V							3
4	V	19 Adjustment for Related Organization	396,780	Heritage Operations Group, LLC	0.00%		(396,780)	4
5	V							5
6	V	34 Adjustment for Related Organization	0	Heritage Manor Real Estate, LLC	0.00%			6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC				7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC				8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC				9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC				10
11	V							11
12	V							12
13	V							13
14	Total		\$ 396,780			\$ 234,830	\$ * (161,950)	14

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

Facility Name & ID Number Heritage Manor-Springfield# 0041699Report 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%	\$	\$	6,941	15	
16	V	2 Food Purchase						2	16	
17	V	3 Housekeeping						0	17	
18	V	4 Laundry						0	18	
19	V	5 Heat & Other Utilities						3,555	19	
20	V	6 Maintenance						35,440	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						3,450	22	
23	V	10 Nursing & Medical Records						0	23	
24	V	11 Activities						1,545	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						2,525	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						21,768	31	
32	V	20 Fees, Subscription, Promotions						14,168	32	
33	V	21 Clerical & General Office Expenses						437,222	33	
34	V	22 Employee Benefits & Payroll Taxes						57,409	34	
35	V	23 Inservice Training & Education						1,798	35	
36	V	24 Travel and Seminar						16,146	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						19,183	38	
39	Total		\$			\$	0	\$ *	621,152	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						16,880	16	
17	V	31 Amortization of Pre-Op & Org						0	17	
18	V	32 Interest						591	18	
19	V	33 Real Estate Taxes						0	19	
20	V	34 Rent-Facility & Grounds						11,044	20	
21	V	35 Rent-Equipment & Vehicles						2,933	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	\$ *	31,448	39

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

Facility Name &amp; ID Number

Heritage Manor-Springfield

# 0041699

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		50.00					\$ 0	18/7	1
2	Memorial Health Ventures			50.00							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-Springfield# 0041699

Report Period Beginning:

01/01/2009Ending: 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	178	\$ 6,941	1
2	2	Food Purchase	Beds	2,634	25	29	0	178	2	2
3	3	Housekeeping	Beds	2,634	25	0	0	178	0	3
4	4	Laundry	Beds	2,634	25	0	0	178	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	52,602	0	178	3,555	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	178	35,440	6
7	7	Other	Beds	2,634	25	0	0	178	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	178	3,450	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	178	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	178	1,545	10
11	12	Social Service	Beds	2,634	25	0	0	178	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	178	2,525	12
13	14	Program Transportation	Beds	2,634	25	0	0	178	0	13
14	15	Other	Beds	2,634	25	0	0	178	0	14
15	17	Administrative	Beds	2,634	25	0	0	178	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	178	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	178	21,768	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	178	14,168	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	178	437,222	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	178	57,409	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	178	1,798	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	178	16,146	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	178	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	283,859	0	178	19,183	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 621,152	25

Facility Name & ID Number Heritage Manor-Springfield

# 0041699

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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

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.

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	\$	178	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	178	16,880	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		178		3
4	32	Interest	Beds	2,634	25	8,747	178	591	4
5	33	Real Estate Taxes	Beds	2,634	25		178		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	178	11,044	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	178	2,933	7
8	36	Other	Beds	2,634	25		178		8
9	38	Medically Nec Transportation	Beds	2,634	25		178		9
10	39	Ancillary Service Centers	Beds	2,634	25		178		10
11	40	Barber and Beauty Shops	Beds	2,634	25		178		11
12	41	Coffee and Gift Shops	Beds	2,634	25		178		12
13	42	Other	Beds	2,634	25		178		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	\$	\$ 31,448	25

Facility Name &amp; ID Number

Heritage Manor-Springfield

# 0041699

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		8	9	10				
						Amount of Note						Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
						Original	Balance							
Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note									
YES	NO													
<b>A. Directly Facility Related</b>														
<b>Long-Term</b>														
1	Bank of Springfield		xx	Mortgage			\$	\$ 2,103,722	03/11	variable	\$ 130,081	1		
2			xx	Loan Fees								2		
3	Bank of Springfield		xx	Van				27,809			1,824	3		
4												4		
5												5		
<b>Working Capital</b>														
6	Bank of Springfield		xx	Accounts Receivable				50,000			5,245	6		
7												7		
8												8		
9	TOTAL Facility Related						\$	\$ 2,181,531			\$ 137,150	9		
<b>B. Non-Facility Related*</b>														
10	Interest Income										(12,470)	10		
11	Allocated Corporate										591	11		
12												12		
13												13		
14	TOTAL Non-Facility Related						\$	\$			\$ (11,879)	14		
15	TOTALS (line 9+line14)						\$	\$ 2,181,531			\$ 125,271	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.		\$	<b>125,231</b>	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>124,588</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(643)</b>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>130,818</b>	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>130,175</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>111,275</b>	8	
	2005	<b>122,304</b>	9	
	2006	<b>116,665</b>	10	
	2007	<b>120,131</b>	11	
	2008	<b>130,175</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-Springfield

# 0041699

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,805 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>630,000</u>	1
2					2
3	TOTALS			\$ <u>630,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	178			\$ 1,900,000	\$		\$	\$
5				1,648,258				
6								
7								
8								
Improvement Type**								
9	1985 Improvements	1985		26,076				
10	1986 Improvements	1986		216,545				
11	1987 Improvements	1987		593,121				
12	1988 Improvements	1988		29,321				
13	1989 Improvements	1989		1,095				
14	1990 Improvements	1990		939				
15	1991 Improvements	1991		32,022				
16	1992 Improvements	1992		32,593				
17	1993 Improvements	1993		105,986				
18	1994 Improvements	1994		59,542				
19	1995 Improvements	1995		36,126				
20	Laundry Chute	1996		4,926				
21	Door Alarm	1996		8,533				
22	Garbage Disposal	1996		1,113				
23	Elevator	1996		11,439				
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34							16,880	
35					244,010		244,010	3,309,909
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-Springfield# 0041699

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	Vent Shaft	1997	\$ 6,267	\$		\$	\$	\$	37
38	Fire Dampers	1997	510						38
39	Computer Cabling	1997	14,518						39
40	Rehab Therapy Room	1997	7,391						40
41	Air Conditioner--Chiller	1997	47,954						41
42	Remodel First Floor	1997	27,570						42
43									43
44	Landscape	1998	2,410						44
45	Vent Work	1998	7,018						45
46	Asphalt Ramp	1998	850						46
47	Room Remodel	1998	1,142						47
48									48
49	Code Alert	1999	7,829						49
50	Wall Paper	1999	704						50
51	Remodel Office Interior	1999	1,248						51
52	Elevator Repair	1999	2,697						52
53	Carpet	1999	1,097						53
54									54
55	Shed Yardmate	2000	522						55
56	A/C Rooftop Unit	2000	2,937						56
57	Sewerline Repair	2000	1,482						57
58									58
59	Facility Renovation--Materials	2001	745,911						59
60	Facility Renovation--Labor	2001	1,463						60
61	Facility Renovation--Interior Design	2001	69,313						61
62	Fire Alarm System	2001	8,718						62
63	Sewer Line Repair	2001	1,787						63
64									64
65	Facility renovations: Paint , wallpaper, fixtures , floor coverings for all resident								65
66	rooms including hallways and common areas								66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 5,668,973	\$ 244,010		\$ 260,890	\$ 16,880	\$ 3,309,909	70

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

Facility Name & ID Number Heritage Manor-Springfield# 0041699

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>		\$ 5,668,973	\$ 244,010		\$ 260,890	\$ 16,880	\$ 3,309,909	1
2	Landscape Design	2002	500						2
3	Freezer Compressor	2002	3,834						3
4	Smoke Detectors	2002	2,560						4
5	Facility Renovation--Materials	2002	186,172						5
6	Facility Renovation--Labor	2002	3,561						6
7	Facility Renovation--Interior Design	2002	15,497						7
8	Phone System	2002	2,064						8
9									9
10	Door Security	2003	2,597						10
11									11
12	Door Replacement	2003	1,216						12
13									13
14									14
15	Shower Room Remodel	2003	14,285						15
16	Hallway carpet	2003	3,889						16
17	Boiler Door	2003	854						17
18									18
19	Shower Room Remodel	2004	36,919						19
20	Elevator Repair	2004	74,457						20
21	Condensing Unit	2004	7,204						21
22	Privacy Door	2004	1,226						22
23									23
24	Controller board	2005	2,460						24
25	Wall Railing	2005	2,837						25
26	A/C Protection	2005	1,318						26
27	Compressor	2005	10,800						27
28	Chiller	2005	2,305						28
29	Rooftop Compressor	2005	4,676						29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,050,204	\$ 244,010		\$ 260,890	\$ 16,880	\$ 3,309,909	34

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

Facility Name & ID Number Heritage Manor-Springfield# 0041699

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>	\$ 6,050,204	\$ 244,010		\$ 260,890	\$ 16,880	\$ 3,309,909		1
2		2006	250,656						2
3	Sprinkler system	2006	2,940						3
4	Door Alarm	2006	12,497						4
5	Stair Treads	2006	2,219						5
6	Roof	2006	6,154						6
7	Fire door								7
8									8
9	HVAC Controls	2007	12,375						9
10		2007							10
11	Sprinkler system	2007	12,140						11
12	Circulating pump	2007	2,693						12
13		2007							13
14	Walk-in freezer	2007	24,013						14
15	Fire Alarm	2007							15
16	Exit Lighting	2007							16
17									17
18	HVAC	2007	18,080						18
19		2007							19
20	Window treatments	2007	3,431						20
21									21
22	Beauty Shop sink, vanity, painting	2008	1,597						22
23									23
24									24
25	HVAC	2009	11,480						25
26	Elevator	2009	53,743						26
27	Boiler	2009	2,914						27
28	Asphalt	2009	9,138						28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,476,274	\$ 244,010		\$ 260,890	\$ 16,880	\$ 3,309,909	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	\$ 1,408,443	\$ 43,654	\$ 43,654	\$		\$ 1,308,336	71
72	Current Year Purchases	59,851						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,468,294	\$ 43,654	\$ 43,654	\$		\$ 1,308,336	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				\$ 38,949	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 38,949	\$	\$	\$		\$	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)	\$ 8,613,517	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 287,664	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 304,544	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,880	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,618,245	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: \$ 7,276 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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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	\$		\$ 255,905	\$		\$ 255,905	1
2	Licensed Speech and Language Development Therapist		hrs			69,918			69,918	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			340,245	1,029		341,274	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				812,376		812,376	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					54,710			54,710	13
14	<b>TOTAL</b>			\$		\$ 720,778	\$ 813,405		\$ 1,534,183	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-Springfield# 0041699Report 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	\$ 68,330	\$	1
2	Cash-Patient Deposits	25,331		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,232,963		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,322		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,401,946	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	630,000		13
14	Buildings, at Historical Cost	6,582,657		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,507,243		16
17	Accumulated Depreciation (book methods)	(4,618,245)		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 (spe <u>Goodwill</u> )	1,638,626		22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 5,740,281	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,142,227	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 295,473	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,331		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	130,817		32
33	Accrued Interest Payable	10,721		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>	\$ 462,342	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,181,531		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>	\$ 2,181,531	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,643,873	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,498,354	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 7,142,227	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,539,828</b>	<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>	\$ <b>4,539,828</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(41,474)	<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>	\$ (41,474)	<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>	\$ <b>4,498,354</b>	<b>24</b> *

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

Facility Name & ID Number Heritage Manor-Springfield# 0041699Report 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	\$ 11,168,929	1
2	Discounts and Allowances for all Levels	(4,348,675)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 6,820,254</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,635,105	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,635,105</b>	<b>8</b>
<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	5,176	12
13	Barber and Beauty Care	13,902	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,474,752	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>\$ 1,493,830</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	12,470	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 12,470</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>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 10,961,659</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,048,491	31
32	Health Care	5,828,784	32
33	General Administration	2,544,395	33
<b>B. Capital Expense</b>			
34	Ownership	562,265	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	12,048	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37	<b>Other</b>	7,150	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 11,003,133</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(41,474)</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (41,474)</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-Springfield**

# **0041699**

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	1,916	2,176	\$ 65,469	\$ 30.09	1
2	Assistant Director of Nursing	1,741	2,296	48,762	21.24	2
3	Registered Nurses	23,086	24,854	651,299	26.20	3
4	Licensed Practical Nurses	56,029	59,995	1,279,602	21.33	4
5	CNAs & Orderlies	114,824	123,750	1,582,598	12.79	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	10,141	10,981	106,479	9.70	10
11	Social Service Workers	5,957	6,684	123,312	18.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	44,709	48,726	465,254	9.55	15
16	Dishwashers					16
17	Maintenance Workers	15,123	16,217	186,803	11.52	17
18	Housekeepers	23,661	25,891	249,961	9.65	18
19	Laundry	10,978	12,300	119,924	9.75	19
20	Administrator	1,900	2,080	84,696	40.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	23,750	30,848	412,539	13.37	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)	333,815	366,798	\$ 5,376,698 *	\$ 14.66	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	18,900		36
37	Medical Records Consultant	1,309		37
38	Nurse Consultant			38
39	Pharmacist Consultant	5,280		39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	2,920		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 28,409		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0		50
51	Licensed Practical Nurses	0		51
52	Certified Nurse Assistants/Aides	0		52
53	TOTAL (lines 50 - 52)	\$		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
<u>Ruth Kopeck</u>				\$ <u>84,696</u>	<u>Workers' Compensation Insurance</u>	\$ <u>113,136</u>	<u>IDPH License Fee</u>	\$ <u>0</u>	
					<u>Unemployment Compensation Insurance</u>		<u>Advertising: Employee Recruitment</u>	<u>3,009</u>	
					<u>FICA Taxes</u>	<u>450,448</u>	<u>Health Care Worker Background Check</u>		
					<u>Employee Health Insurance</u>	<u>428,233</u>	(Indicate # of checks performed _____)	<u>6,690</u>	
					<u>Employee Meals</u>		<u>Central Office</u>	<u>14,168</u>	
					<u>Illinois Municipal Retirement Fund (IMRF)*</u>				
						<u>0</u>		<u>6,639</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>					<u>Other Benefits</u>	<u>61,744</u>	<u>Dues &amp; Subscriptions</u>	<u>13,584</u>	
<b>(List each licensed administrator separately.)</b>				\$ <u>84,696</u>	<u>Central Office Allocation</u>	<u>57,409</u>	<u>License &amp; Fees</u>	<u>2,788</u>	
<b>B. Administrative - Other</b>									
Description			Amount				<u>Less: Public Relations Expense</u>	<u>(6,639)</u>	
			\$				<u>Non-allowable advertising</u>	<u>(1,359)</u>	
							<u>Yellow page advertising</u>	<u>( 0 )</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$		<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	\$ <u>1,110,970</u>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	\$ <u>38,880</u>	
<b>(Attach a copy of any management service agreement)</b>									
<b>C. Professional Services</b>					<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
<u>Heritage Operations Group</u>	<u>Mgt Fee</u>		\$ <u>396,780</u>			\$	<u>Out-of-State Travel</u>	\$	
<u>Sulaski &amp; Webb</u>			<u>13,900</u>						
							<u>In-State Travel</u>		
								<u>3,196</u>	
								<u>146</u>	
							<u>Seminar Expense</u>	<u>4,327</u>	
								<u>0</u>	
							<u>Central Office</u>	<u>16,146</u>	
							<u>Entertainment Expense</u>	<u>( )</u>	
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>				<b>TOTAL</b>		\$	(agree to Sch. V, line 24, col. 8)		
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>			\$ <u>451,504</u>				<b>TOTAL</b>	\$ <u>23,815</u>	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Heritage Manor-Springfield# 0041699Report 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. \$ 97,455  
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.