



Facility Name & ID Number Heritage Manor-Bloomington

# 0048157 Report Period Beginning: 1-01-10 Ending: 12-31-10

**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	111	Skilled (SNF)	111	40,515	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	111	TOTALS	111	40,515	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,491	5,918	4,120	33,529	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,491	5,918	4,120	33,529	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.76%**

**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 4,120

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 &amp; ID Number

Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

1-01-10

Ending:

12-31-10

## 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	340,587	29,595		370,182		370,182	4,424	374,606		1
2	Food Purchase		232,284		232,284		232,284	(1,045)	231,239		2
3	Housekeeping	103,729	29,535		133,264		133,264		133,264		3
4	Laundry	78,015	13,997		92,012		92,012		92,012		4
5	Heat and Other Utilities			124,945	124,945		124,945	1,912	126,857		5
6	Maintenance	117,326	52,071	65,791	235,188		235,188	13,171	248,359		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	639,657	357,482	190,736	1,187,875		1,187,875	18,462	1,206,337		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,300	15,300		15,300	3,250	18,550		9
10	Nursing and Medical Records	1,933,125	187,301	16,319	2,136,745		2,136,745		2,136,745		10
10a	Therapy		283,762	814,095	1,097,857	(321,908)	775,949	190,480	966,429		10a
11	Activities	78,212	1,540		79,752		79,752	4	79,756		11
12	Social Services	57,697		2,781	60,478		60,478		60,478		12
13	CNA Training	10,070	2,960		13,030		13,030	1,467	14,497		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,079,104	475,563	848,495	3,403,162	(321,908)	3,081,254	195,201	3,276,455		16
	<b>C. General Administration</b>										
17	Administrative	75,161			75,161		75,161	93,968	169,129		17
18	Directors Fees										18
19	Professional Services			280,371	280,371		280,371	(258,415)	21,956		19
20	Dues, Fees, Subscriptions & Promotions			102,786	102,786	(60,773)	42,013	(1,995)	40,018		20
21	Clerical & General Office Expenses	216,320	32,648	16,121	265,089		265,089	192,351	457,440		21
22	Employee Benefits & Payroll Taxes			562,486	562,486		562,486	35,295	597,781		22
23	Inservice Training & Education			6,510	6,510		6,510	(4,511)	1,999		23
24	Travel and Seminar			368	368		368	1,631	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			57,666	57,666		57,666	12,626	70,292		26
27	Other (specify):*			31,403	31,403		31,403	(31,200)	203		27
28	<b>TOTAL General Administration</b>	291,481	32,648	1,057,711	1,381,840	(60,773)	1,321,067	39,750	1,360,817		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,010,242	865,693	2,096,942	5,972,877	(382,681)	5,590,196	253,413	5,843,609		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:

1-01-10

Ending:

12-31-10

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							200,103	200,103			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,079	8,079		8,079	109,007	117,086			32
33	Real Estate Taxes							71,669	71,669			33
34	Rent-Facility & Grounds			486,180	486,180		486,180	(484,658)	1,522			34
35	Rent-Equipment & Vehicles			5,489	5,489		5,489	1,348	6,837			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			499,748	499,748		499,748	(102,531)	397,217			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					321,908	321,908		321,908			39
40	Barber and Beauty Shops											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>					382,681	382,681		382,681			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,010,242	865,693	2,596,690	6,472,625		6,472,625	150,882	6,623,507			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space	(5,830)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(615)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)	(4,924)	23		16
17	Non-Care Related Fees	(528)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,234)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(16,273)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,200)	27		24
25	Fund Raising, Advertising and Promotional	(12,845)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (79,449)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	230,331		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 230,331		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ 150,882		37

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

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

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

Heritage Manor-Bloomington

ID# 0048157

Report Period Beginning: 1-01-10

Ending: 12-31-10

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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		(16,273)	19	22
23				23
24		(31,200)	27	24
25		(12,845)	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>	(60,846)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

1-01-10

Ending:

12-31-10

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	4,424	0	0	0	0	0	0	0	0	4,424	1
2	Food Purchase	0	0	(1,045)	0	0	0	0	0	0	0	0	(1,045)	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	1,912	0	0	0	0	0	0	0	0	1,912	5
6	Maintenance	0	0	13,171	0	0	0	0	0	0	0	0	13,171	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>18,462</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>18,462</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	3,250	0	0	0	0	0	0	0	0	3,250	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	190,480	0	0	0	0	0	0	0	0	0	190,480	10a
11	Activities	0	0	4	0	0	0	0	0	0	0	0	4	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,467	0	0	0	0	0	0	0	0	1,467	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>190,480</b>	<b>4,721</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>195,201</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	93,968	0	0	0	0	0	0	0	0	93,968	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,273)	(261,328)	19,186	0	0	0	0	0	0	0	0	(258,415)	19
20	Fees, Subscriptions & Promotions	(13,373)	0	11,378	0	0	0	0	0	0	0	0	(1,995)	20
21	Clerical & General Office Expenses	0	0	192,351	0	0	0	0	0	0	0	0	192,351	21
22	Employee Benefits & Payroll Taxes	0	0	35,295	0	0	0	0	0	0	0	0	35,295	22
23	Inservice Training & Education	(4,924)	0	413	0	0	0	0	0	0	0	0	(4,511)	23
24	Travel and Seminar	(7,234)	0	8,865	0	0	0	0	0	0	0	0	1,631	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	12,626	0	0	0	0	0	0	0	0	12,626	26
27	Other (specify):*	(31,200)	0	0	0	0	0	0	0	0	0	0	(31,200)	27
28	<b>TOTAL General Administration</b>	<b>(73,004)</b>	<b>(261,328)</b>	<b>374,082</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>39,750</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(73,004)</b>	<b>(70,848)</b>	<b>397,265</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>253,413</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	189,545	0	10,558	0	0	0	0	0	0	0	200,103	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(615)	108,952	0	670	0	0	0	0	0	0	0	109,007	32
33	Real Estate Taxes	0	71,608	0	61	0	0	0	0	0	0	0	71,669	33
34	Rent-Facility & Grounds	(5,830)	(486,180)	0	7,352	0	0	0	0	0	0	0	(484,658)	34
35	Rent-Equipment & Vehicles	0	0	0	1,348	0	0	0	0	0	0	0	1,348	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(6,445)</b>	<b>(116,075)</b>	<b>0</b>	<b>19,989</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(102,531)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(79,449)</b>	<b>(186,923)</b>	<b>397,265</b>	<b>19,989</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>150,882</b>	<b>45</b>



Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

1-01-10

Ending:

12-31-10

**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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$		1
2	V	10a Adjustment for Related Organization		GreenTree Pharmacy	0.00%	190,480	190,480	2
3	V							3
4	V	19 Adjustment for Related Organization	261,328	Heritage Operations Group, LLC	0.00%		(261,328)	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		71,608	71,608	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		102,129	102,129	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		189,545	189,545	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		\$ 747,508			\$ 560,585	\$ * (186,923)	14

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

Facility Name & ID Number Heritage Manor-Bloomington# 0048157Report Period Beginning: 1-01-10Ending: 12-31-10

## 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.		\$	4,424	15
16	V	2 Food Purchase					(1,045)	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,912	19
20	V	6 Maintenance					13,171	20
21	V	7 Other					0	21
22	V	9 Medical Director					3,250	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					4	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,467	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					93,968	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					19,186	31
32	V	20 Fees, Subscription, Promotions					11,378	32
33	V	21 Clerical & General Office Expenses					192,351	33
34	V	22 Employee Benefits & Payroll Taxes					35,295	34
35	V	23 Inservice Training & Education					413	35
36	V	24 Travel and Seminar					8,865	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					12,626	38
39	Total		\$			\$	0	\$ * 397,265 39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Enterprises, Inc.		\$	\$	0 15
16	V	30	Depreciation						10,558 16
17	V	31	Amortization of Pre-Op & Org						0 17
18	V	32	Interest						670 18
19	V	33	Real Estate Taxes						61 19
20	V	34	Rent-Facility & Grounds						7,352 20
21	V	35	Rent-Equipment & Vehicles						1,348 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								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			\$	0	\$ * 19,989 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:

1-01-10

Ending:

12-31-10

## 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:

1-01-10

Ending: 12-31-10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 104,969	\$ 104,969	111	\$ 4,424	1
2	2	Food Purchase	Beds	2,634	25	(24,794)	0	111	(1,045)	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	45,364	0	111	1,912	5
6	6	Maintenance	Beds	2,634	25	312,555	75,007	111	13,171	6
7	7	Other	Beds	2,634	25	0	0	111	0	7
8	9	Medical Director	Beds	2,634	25	77,111	0	111	3,250	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	77,111	111	0	9
10	11	Activities	Beds	2,634	25	95	0	111	4	10
11	12	Social Service	Beds	2,634	25	0	0	111	0	11
12	13	Nurse Aide Training	Beds	2,634	25	34,804	0	111	1,467	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	2,229,831	2,229,831	111	93,968	15
16	18	Directors Fees	Beds	2,634	25	0	0	111	0	16
17	19	Professional Services	Beds	2,634	25	455,276	0	111	19,186	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	269,994	0	111	11,378	18
19	21	Clerical & General Office Expens	Beds	2,634	25	4,564,447	4,163,572	111	192,351	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	837,533	0	111	35,295	20
21	23	Inservice Training & Education	Beds	2,634	25	9,793	0	111	413	21
22	24	Travel and Seminar	Beds	2,634	25	210,373	0	111	8,865	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	299,608	0	111	12,626	24
25	TOTALS					\$ 9,426,959	\$ 6,650,490		\$ 397,265	25

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

1-01-10

Ending: 12-31-10

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	250,538	111	10,558	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		111		3
4	32	Interest	Beds	2,634	25	15,900	111	670	4
5	33	Real Estate Taxes	Beds	2,634	25	1,448	111	61	5
6	34	Rent-Facility & Grounds	Beds	2,634	25	174,472	111	7,352	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	31,994	111	1,348	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					\$ 474,352	\$	\$ 19,989	25

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

1-01-10

Ending:

12-31-10

**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			\$	\$ 1,452,464	3/2011	variable	\$ 102,129	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							8,079	6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$	\$ 1,452,464			\$ 117,031	9							
<b>B. Non-Facility Related*</b>																			
10	Interest Income										(615)	10							
11	Allocated Corporate										670	11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 55	14							
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 1,452,464			\$ 117,086	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2009 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>71,608</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>71,608</b>	3
4. Real Estate Tax accrual used for 2010 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>71,608</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	<b>76,294</b>	8
	2006	<b>76,940</b>	9
	2007	<b>75,436</b>	10
	2008	<b>72,139</b>	11
	2009	<b>71,608</b>	12

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.**



**2009 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor-Bloomington COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048157

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>2104227012</u>	<u>Heritage Manor bloomington</u>	\$ <u>71,608.00</u>	\$ <u>71,608.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>71,608.00</u>	\$ <u>71,608.00</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   x   NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

1-01-10

Ending:

12-31-10

**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:**

A. Land.

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

Facility Name & ID Number Heritage Manor-Bloomington# 0048157

Report Period Beginning:

1-01-10

Ending:

12-31-10**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	111				\$ 560,548	\$		\$	\$	\$	4
5					221,147						5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	1978 Improvements		1978		14,607						9
10	1979 Improvements		1979		95,460						10
11	1980 Improvements		1980		75,591						11
12	1981 Improvements		1981		11,544						12
13	1982 Improvements		1982		9,256						13
14	1983 Improvements		1983		13,130						14
15	1984 Improvements		1984		7,215						15
16	1985 Improvements		1985		45,885						16
17	1986 Improvements		1986		13,469						17
18	1988 Improvements		1988		83,109						18
19	1989 Improvements		1989		2,439						19
20	1990 Improvements		1990		30,676						20
21	1991 Improvements		1991		4,207						21
22	1992 Improvements		1992		1,208						22
23	1993 Improvements		1993		97,303						23
24	1994 Improvements		1994		29,638						24
25	1995 Improvements		1995		121,304						25
26	BOILER		1996		17,850						26
27	EXHAUST HOOD		1996		1,075						27
28	CODE ALERT		1996		1,852						28
29	PHONE SYSTEM		1996		2,339						29
30	INTERIOR REMODEL		1996		103,103						30
31											31
32											32
33	C/O Allocation							10,558	10,558		33
34	Book Depreciation					161,186		161,186		1,571,262	34
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Heritage Manor-Bloomington# 0048157

Report Period Beginning:

1-01-10

Ending:

12-31-10**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 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 Adj to Capital Report	2000	(2,383)						63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,187,775	\$ 161,186		\$ 171,744	\$ 10,558	\$ 1,571,262	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:

1-01-10

Ending:

12-31-10**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,187,775	\$ 161,186		\$ 171,744	\$ 10,558	\$ 1,571,262	1
2	2001	2,456						2
3	2001	1,950						3
4	2001	3,965						4
5	2001	1,805						5
6	2001	2,000						6
7	2001	1,883						7
8								8
9	2002	14,551						9
10	2002	1,862						10
11	2002	3,885						11
12	2002	1,280						12
13	2002	957						13
14	2002	5,283						14
15								15
16	2003	5,970						16
17	2003	111,250						17
18	2003	31,119						18
19	2003	3,862						19
20	2003	1,315						20
21	2003	3,898						21
22	2003	857						22
23	2003	2,762						23
24	2003	1,450						24
25	2003	2,003						25
26	2003	(14,958)						26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,379,180	\$ 161,186		\$ 171,744	\$ 10,558	\$ 1,571,262	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:

1-01-10

Ending:

12-31-10**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,379,180	\$ 161,186		\$ 171,744	\$ 10,558	\$ 1,571,262	1
2	2004	3,823						2
3	2004	1,478						3
4	2004	2,825						4
5	2004	1,646						5
6	2004	645						6
7	2004	6,030						7
8	2004	4,011						8
9								9
10	2005	12,431						10
11	2005	1,360						11
12	2005	596						12
13	2005	2,153						13
14	2005	2,100						14
15								15
16	2006	6,791						16
17	2006	6,900						17
18	2006	11,650						18
19	2006	5,015						19
20	2006	4,902						20
21	2006	2,350						21
22	2006	27,469						22
23	2006	3,750						23
24	2006	1,820						24
25	2006	1,199						25
26	2006	1,335						26
27	2006	1,072						27
28	2006	2,884						28
29	2006	(722)						29
30								30
31								31
32								32
33								33
34		\$ 3,494,693	\$ 161,186		\$ 171,744	\$ 10,558	\$ 1,571,262	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:

1-01-10

Ending:

12-31-10**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	10
	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>		\$ 3,494,693	\$ 161,186		\$ 171,744	\$ 10,558	\$ 1,571,262	1
2	<u>Resident Rooms Remodel -- Paint and flooring</u>	2007	13,957						2
3	<u>Sprinkler</u>	2007	1,152						3
4	<u>Compressor</u>	2007	4,006						4
5	<u>Condensor</u>	2007	2,250						5
6	<u>Water Heater</u>	2007	7,359						6
7	<u>Therapy Room Remodel-- Paint &amp; Flooring</u>	2007	2,527						7
8	<u>Window treatments</u>	2007	583						8
9	<u>Cooler</u>	2007	642						9
10	<u>Boiler</u>	2007	4,803						10
11	<u>Adj to Capital Report</u>	2007	(8,178)						11
12	<u>Heat/Cool Units</u>	2008	5,420						12
13	<u>Replace Fire Escape</u>	2008	13,577						13
14	<u>Schematic Design (Architect Fees) Facility Renovation</u>	2008	26,038						14
15	<u>Water Heater --Backflow</u>	2008	4,926						15
16	<u>Fire Alarm</u>	2008	63,563						16
17	<u>Water Heater</u>	2008	6,057						17
18	<u>Adj to Capital Report</u>	2008	(19,981)						18
19	<u>HVAC Unit</u>	2009	7,035						19
20	<u>Compressor</u>	2009	4,658						20
21	<u>HVAC Renovation: Boilers, ducts, hvac units &amp; labor</u>	2009	360,549						21
22	<u>Windows</u>	2009	148,790						22
23									23
24	<u>HVAC Renovation: Boilers, ducts, hvac units &amp; labor</u>	2010	15,355						24
25	<u>Architect, engineering fees</u>	2010	87,978						25
26	<u>trane compressor</u>	2010	6,255						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,254,014	\$ 161,186		\$ 171,744	\$ 10,558	\$ 1,571,262	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:

1-01-10

Ending:

12-31-10

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	\$ 1,196,655	\$ 28,359	\$ 28,359	\$		\$ 1,085,932	71
72	Current Year Purchases	50,001						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,246,656	\$ 28,359	\$ 28,359	\$		\$ 1,085,932	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	2	
	Reference	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)	\$ 5,617,246	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 189,545	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 200,103	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,558	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,657,194	85

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

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

G. Construction-in-Progress

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

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

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



Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

Report Period Beginning:

1-01-10

Ending: 12-31-10

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.

YES  NO

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

\*\*

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: \$ 5,489 Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		2,960		2,960
3	Classroom Wages (a)				
4	Clinical Wages (b)		10,070		10,070
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 13,030	\$	\$ 13,030
10	SUM OF line 9, col. 1 and 2 (e)	\$	13,030		

**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	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 295,838	\$		\$ 295,838	1
2	Licensed Speech and Language Development Therapist		hrs			88,080			88,080	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			391,176	855		392,031	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				282,907		282,907	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					39,001			39,001	13
14	<b>TOTAL</b>			\$		\$ 814,095	\$ 283,762		\$ 1,097,857	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: 1-01-10

Ending:

12-31-10

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 8,195	\$	1
2	Cash-Patient Deposits	40,346		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	169,870		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,349		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,257,878)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ (1,022,118)	\$	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</b> (sum of lines 11 thru 23)	\$	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ (1,022,118)	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 235,714	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,346		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	197,437		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,713		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</b> (sum of lines 26 thru 37)	\$ 499,210	\$	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</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 499,210	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,521,328)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ (1,022,118)	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,312,297)</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>(1,312,297)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(209,031)</b>	<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>	\$ <b>(209,031)</b>	<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>(1,521,328)</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,939,161	1
2	Discounts and Allowances for all Levels	(2,440,839)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,498,322</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,290,509	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,290,509</b>	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	2,893	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,830	16
17	Sale of Drugs	450,490	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,157	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 463,370</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	615	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 615</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Other</u>	10,778	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 10,778</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,263,594</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,187,875	31
32	Health Care	3,403,162	32
33	General Administration	1,381,840	33
<b>B. Capital Expense</b>			
34	Ownership	499,748	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,472,625</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(209,031)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (209,031)</b>	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:

1-01-10

Ending:

12-31-10

**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	\$ 59,953	\$ 27.76	1
2	Assistant Director of Nursing	1,900	2,160	43,462	20.12	2
3	Registered Nurses	13,001	13,461	440,084	32.69	3
4	Licensed Practical Nurses	19,145	20,242	434,382	21.46	4
5	CNAs & Orderlies	73,713	77,888	889,820	11.42	5
6	CNA Trainees	1,500	1,500	10,070	6.71	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,748	3,111	65,424	21.03	8
9	Activity Director					9
10	Activity Assistants	7,032	7,387	78,212	10.59	10
11	Social Service Workers	3,890	4,104	57,697	14.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,835	25,812	340,587	13.19	15
16	Dishwashers					16
17	Maintenance Workers	8,405	8,928	117,326	13.14	17
18	Housekeepers	10,603	11,329	103,729	9.16	18
19	Laundry	6,400	6,851	78,015	11.39	19
20	Administrator	1,900	2,080	75,161	36.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,148	14,593	216,320	14.82	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	\$ 3,010,242 *	\$ 14.93	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	6,660		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	2,781		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 26,341		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			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Susan Holifield			\$ 75,161	Workers' Compensation Insurance	\$ 99,700	IDPH License Fee	\$ 0		
				Unemployment Compensation Insurance	20,875	Advertising: Employee Recruitment	15,494		
				FICA Taxes	230,284	Health Care Worker Background Check (Indicate # of checks performed _____)	3,556		
				Employee Health Insurance	186,907	Patient Background Checks			
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*	0		8,986		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,161	Other Benefits	24,720	Dues & Subscriptions	7,054		
B. Administrative - Other				Central Office Allocation	35,295	License & Fees	3,064		
Description			Amount			Central Office Allocation	11,378		
			\$			Less: Public Relations Expense	(8,986)		
						Non-allowable advertising	(528)		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 597,781	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 40,018		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Heritage Operations Group	Mgt Fee		\$ 261,328			\$	Out-of-State Travel	\$	
McQuellen Consulting	R/E appeals		2,770						
							In-State Travel		
								0	
								40	
							Seminar Expense	328	
							Central Office	1,631	
Legal adj to Zero			16,273				Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 280,371	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,999	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

Report Period Beginning: 1-01-10

Ending:

12-31-10

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heritage Manor-Bloomington# 0048157Report Period Beginning: 1-01-10Ending: 12-31-10**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.  
Heritage Manor Bloomington 38349 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,773  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 530
- (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.