

Facility Name & ID Number Heritage Manor-Pana

0048884 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	151	Skilled (SNF)	151	55,115	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	151	TOTALS	151	55,115	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	24,184	8,513	6,426	39,123	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,184	8,513	6,426	39,123	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.98%

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 07/2007

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 6,426

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCURAL 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-Pana

0048884

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
	A. General Services										
1	Dietary	251,212	16,998		268,210		268,210	6,018	274,228		1
2	Food Purchase		251,476		251,476		251,476	(1,421)	250,055		2
3	Housekeeping	96,337	25,432		121,769		121,769		121,769		3
4	Laundry	67,981	19,799		87,780		87,780		87,780		4
5	Heat and Other Utilities			150,503	150,503		150,503	2,601	153,104		5
6	Maintenance	88,252	69,793	38,355	196,400		196,400	17,918	214,318		6
7	Other (specify):*										7
8	TOTAL General Services	503,782	383,498	188,858	1,076,138		1,076,138	25,116	1,101,254		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400	4,421	12,821		9
10	Nursing and Medical Records	1,988,578	94,767	21,019	2,104,364		2,104,364		2,104,364		10
10a	Therapy		396,879	802,864	1,199,743	(461,338)	738,405	253,153	991,558		10a
11	Activities	55,162	987		56,149		56,149	5	56,154		11
12	Social Services	72,539		3,210	75,749		75,749		75,749		12
13	CNA Training		302		302		302	1,995	2,297		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,116,279	492,935	835,493	3,444,707	(461,338)	2,983,369	259,574	3,242,943		16
	C. General Administration										
17	Administrative	102,794			102,794		102,794	127,830	230,624		17
18	Directors Fees										18
19	Professional Services			292,902	292,902		292,902	(266,802)	26,100		19
20	Dues, Fees, Subscriptions & Promotions			117,871	117,871	(82,673)	35,198	(2,886)	32,312		20
21	Clerical & General Office Expenses	186,018	25,746	7,580	219,344		219,344	261,667	481,011		21
22	Employee Benefits & Payroll Taxes			569,314	569,314		569,314	48,013	617,327		22
23	Inservice Training & Education			5,131	5,131		5,131	(3,132)	1,999		23
24	Travel and Seminar			1,295	1,295		1,295	704	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			62,164	62,164		62,164	17,176	79,340		26
27	Other (specify):*			26,427	26,427		26,427	(24,000)	2,427		27
28	TOTAL General Administration	288,812	25,746	1,082,684	1,397,242	(82,673)	1,314,569	158,570	1,473,139		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,908,873	902,179	2,107,035	5,918,087	(544,011)	5,374,076	443,260	5,817,336		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Heritage Manor-Pana

#0048884

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							249,501	249,501			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,987	10,987		10,987	219,258	230,245			32
33	Real Estate Taxes							68,535	68,535			33
34	Rent-Facility & Grounds			661,380	661,380		661,380	(651,378)	10,002			34
35	Rent-Equipment & Vehicles			26,265	26,265		26,265	1,834	28,099			35
36	Other (specify):*											36
37	TOTAL Ownership			698,632	698,632		698,632	(112,250)	586,382			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					461,338	461,338		461,338			39
40	Barber and Beauty Shops		384	21,334	21,718		21,718		21,718			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					82,673	82,673		82,673			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		384	21,334	21,718	544,011	565,729		565,729			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,908,873	902,563	2,827,001	6,638,437		6,638,437	331,010	6,969,447			45

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

Facility Name & ID Number Heritage Manor-Pana

0048884

Report Period Beginning:

1-01-10

Ending:

12-31-10

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(8,610)	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)	(3,693)	23		16
17	Non-Care Related Fees	(830)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,356)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,869)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)	27		24
25	Fund Raising, Advertising and Promotional	(17,534)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (68,892)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	399,902		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 399,902		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 331,010		37

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

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

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

Heritage Manor-Pana

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Report Period Beginning: 1-01-10

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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		(830)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(2,869)	19	22
23				23
24		(24,000)	27	24
25		(17,534)	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	Total		(45,233)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Pana# 0048884

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	6,018	0	0	0	0	0	0	0	0	6,018	1
2	Food Purchase	0	0	(1,421)	0	0	0	0	0	0	0	0	(1,421)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,601	0	0	0	0	0	0	0	0	2,601	5
6	Maintenance	0	0	17,918	0	0	0	0	0	0	0	0	17,918	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	25,116	0	0	0	0	0	0	0	0	25,116	8
	B. Health Care and Programs													
9	Medical Director	0	0	4,421	0	0	0	0	0	0	0	0	4,421	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	253,153	0	0	0	0	0	0	0	0	0	253,153	10a
11	Activities	0	0	5	0	0	0	0	0	0	0	0	5	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,995	0	0	0	0	0	0	0	0	1,995	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	253,153	6,421	0	0	0	0	0	0	0	0	259,574	16
	C. General Administration													
17	Administrative	0	0	127,830	0	0	0	0	0	0	0	0	127,830	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,869)	(290,033)	26,100	0	0	0	0	0	0	0	0	(266,802)	19
20	Fees, Subscriptions & Promotions	(18,364)	0	15,478	0	0	0	0	0	0	0	0	(2,886)	20
21	Clerical & General Office Expenses	0	0	261,667	0	0	0	0	0	0	0	0	261,667	21
22	Employee Benefits & Payroll Taxes	0	0	48,013	0	0	0	0	0	0	0	0	48,013	22
23	Inservice Training & Education	(3,693)	0	561	0	0	0	0	0	0	0	0	(3,132)	23
24	Travel and Seminar	(11,356)	0	12,060	0	0	0	0	0	0	0	0	704	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	17,176	0	0	0	0	0	0	0	0	17,176	26
27	Other (specify):*	(24,000)	0	0	0	0	0	0	0	0	0	0	(24,000)	27
28	TOTAL General Administration	(60,282)	(290,033)	508,885	0	0	0	0	0	0	0	0	158,570	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(60,282)	(36,880)	540,422	0	0	0	0	0	0	0	0	443,260	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Pana

0048884

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 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)	
	D. Ownership													
30	Depreciation	0	235,138	0	14,363	0	0	0	0	0	0	0	249,501	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,610)	226,956	0	912	0	0	0	0	0	0	0	219,258	32
33	Real Estate Taxes	0	68,452	0	83	0	0	0	0	0	0	0	68,535	33
34	Rent-Facility & Grounds	0	(661,380)	0	10,002	0	0	0	0	0	0	0	(651,378)	34
35	Rent-Equipment & Vehicles	0	0	0	1,834	0	0	0	0	0	0	0	1,834	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,610)	(130,834)	0	27,194	0	0	0	0	0	0	0	(112,250)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(68,892)	(167,714)	540,422	27,194	0	0	0	0	0	0	0	331,010	45

Facility Name & ID Number

Heritage Manor-Pana

0048884

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$		1
2	V	10a Adjustment for Related Organization		GreenTree Pharmacy	0.00%	253,153	253,153	2
3	V							3
4	V	19 Adjustment for Related Organization	290,033	Heritage Operations Group, LLC	0.00%		(290,033)	4
5	V							5
6	V	34 Adjustment for Related Organization	661,380	Heritage Manor Real Estate, LLC	0.00%		(661,380)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		68,452	68,452	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		207,354	207,354	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		235,138	235,138	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		19,602	19,602	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 951,413			\$ 783,699	\$ * (167,714)	14

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

Facility Name & ID Number Heritage Manor-Pana# 0048884Report 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.		\$	\$ 6,018	15
16	V	2 Food Purchase					(1,421)	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					2,601	19
20	V	6 Maintenance					17,918	20
21	V	7 Other					0	21
22	V	9 Medical Director					4,421	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					5	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,995	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					127,830	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					26,100	31
32	V	20 Fees, Subscription, Promotions					15,478	32
33	V	21 Clerical & General Office Expenses					261,667	33
34	V	22 Employee Benefits & Payroll Taxes					48,013	34
35	V	23 Inservice Training & Education					561	35
36	V	24 Travel and Seminar					12,060	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					17,176	38
39	Total		\$			\$	0	\$ * 540,422 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											14,363	16
17	V	31	Amortization of Pre-Op & Org											0	17
18	V	32	Interest											912	18
19	V	33	Real Estate Taxes											83	19
20	V	34	Rent-Facility & Grounds											10,002	20
21	V	35	Rent-Equipment & Vehicles											1,834	21
22	V	36	Other											0	22
23	V	38	Medically Nec Transportation											0	23
24	V	39	Ancillary Service Centers											0	24
25	V	40	Barber and Beauty Shops											0	25
26	V	41	Coffee and Gift Shops											0	26
27	V	42	Other											0	27
28	V														28
29	V														29
30	V														30
31	V														31
32	V														32
33	V														33
34	V														34
35	V														35
36	V														36
37	V														37
38	V														38
39	Total				\$						\$	0	\$ *	27,194	39

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

Facility Name & ID Number Heritage Manor-Pana # 0048884 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	2	3	4	5	6		7		8	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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-Pana

0048884 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	151	\$ 6,018	1
2	2	Food Purchase	Beds	2,634	25	(24,794)	0	151	(1,421)	2
3	3	Housekeeping	Beds	2,634	25	0	0	151	0	3
4	4	Laundry	Beds	2,634	25	0	0	151	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	45,364	0	151	2,601	5
6	6	Maintenance	Beds	2,634	25	312,555	75,007	151	17,918	6
7	7	Other	Beds	2,634	25	0	0	151	0	7
8	9	Medical Director	Beds	2,634	25	77,111	0	151	4,421	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	77,111	151	0	9
10	11	Activities	Beds	2,634	25	95	0	151	5	10
11	12	Social Service	Beds	2,634	25	0	0	151	0	11
12	13	Nurse Aide Training	Beds	2,634	25	34,804	0	151	1,995	12
13	14	Program Transportation	Beds	2,634	25	0	0	151	0	13
14	15	Other	Beds	2,634	25	0	0	151	0	14
15	17	Administrative	Beds	2,634	25	2,229,831	2,229,831	151	127,830	15
16	18	Directors Fees	Beds	2,634	25	0	0	151	0	16
17	19	Professional Services	Beds	2,634	25	455,276	0	151	26,100	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	269,994	0	151	15,478	18
19	21	Clerical & General Office Expens	Beds	2,634	25	4,564,447	4,163,572	151	261,667	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	837,533	0	151	48,013	20
21	23	Inservice Training & Education	Beds	2,634	25	9,793	0	151	561	21
22	24	Travel and Seminar	Beds	2,634	25	210,373	0	151	12,060	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	151	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	299,608	0	151	17,176	24
25	TOTALS					\$ 9,426,959	\$ 6,650,490		\$ 540,422	25

Facility Name & ID Number Heritage Manor-Pana

0048884

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	\$	151	\$	1
2	30	Depreciation	Beds	2,634	25	250,538	151	14,363	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		151		3
4	32	Interest	Beds	2,634	25	15,900	151	912	4
5	33	Real Estate Taxes	Beds	2,634	25	1,448	151	83	5
6	34	Rent-Facility & Grounds	Beds	2,634	25	174,472	151	10,002	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	31,994	151	1,834	7
8	36	Other	Beds	2,634	25		151		8
9	38	Medically Nec Transportation	Beds	2,634	25		151		9
10	39	Ancillary Service Centers	Beds	2,634	25		151		10
11	40	Barber and Beauty Shops	Beds	2,634	25		151		11
12	41	Coffee and Gift Shops	Beds	2,634	25		151		12
13	42	Other	Beds	2,634	25		151		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	\$	\$ 27,194	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America		xx	Mortgage			\$	\$ 5,061,912	3/2011	variable	\$ 207,354	1							
2	Bank of America		xx	Loan Fees							19,602	2							
3												3							
4												4							
5												5							
Working Capital																			
6	Bank of America		xx	Accounts Receivable							10,987	6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$ 5,061,912			\$ 237,943	9							
B. Non-Facility Related*																			
10	Interest Income										(8,610)	10							
11	Allocated Corporate										912	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (7,698)	14							
15	TOTALS (line 9+line14)						\$	\$ 5,061,912			\$ 230,245	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.)		\$	<u>68,452</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>68,452</u>	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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>68,452</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	<u>67,680</u>	8
	2006	<u>67,830</u>	9
	2007	<u>66,523</u>	10
	2008	<u>67,555</u>	11
	2009	<u>68,452</u>	12

	FOR BHF USE ONLY		
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-Pana COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0048884

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 Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>11252222301400</u>	<u>nursing home</u>	\$ <u>67,737.00</u>	\$ <u>67,737.00</u>
2.	<u>11252222301300</u>	_____	\$ <u>715.00</u>	\$ <u>715.00</u>
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>68,452.00</u></u>	\$ <u><u>68,452.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly

used for nursing home services? YES NO

If YES, attach an explanation 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-Pana

0048884

Report Period Beginning:

1-01-10

Ending:

12-31-10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,284 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				\$ <u>51,055</u>	1
2					2
3	TOTALS			\$ <u>51,055</u>	3

Facility Name & ID Number Heritage Manor-Pana

0048884

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	151				\$ 3,943,054	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Smoke Detectors		1997		1,113						9
10											10
11	Seal BlackTop/Parking Lot		1996		2,680						11
12	Heritage Manor Sign		1996		2,192						12
13	Laundry Room Central A/C		1996		3,019						13
14											14
15	Generator Repair		1998		1,559						15
16	Roof		1998		26,420						16
17											17
18	roof		1999		113,936						18
19											19
20	Heat / Cool Unit		2000		1,170						20
21	Roof Repair Walkway		2000		1,715						21
22											22
23											23
24	Tile Floor		2001		1,646						24
25	Heat/Cool Unit		2001		1,180						25
26											26
27	Day Room Carpet		2002		1,225						27
28	Hot Water Heater		2002		2,224						28
29	Sewar repair		2002		1,965						29
30											30
31											31
32											32
33	C/O Allocation							14,363	14,363		33
34	Book Depreciation					180,894		180,894			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-Pana

0048884

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 Sealcoat Parking Lot	2003	\$ 3,338	\$		\$	\$	\$	37
38 A/C unit	2003	1,153						38
39								39
40 Carpeting	2003	5,655						40
41 Ansul System	2003	1,803						41
42								42
43 Booster Heater	2004	1,151						43
44 Energy Mgt System	2004	12,890						44
45 Exterior Doors	2004	1,247						45
46 Heat/Cool Units	2004	7,372						46
47 Drive way repairs	2004	1,765						47
48 Carpeting	2004	13,652						48
49 Sewer Replacement	2004	2,847						49
50								50
51 Heat/Cool Units	2005	13,286						51
52 Unerfloor Ductwork	2005	1,100						52
53 Sidewalks	2005	9,208						53
54 Roof	2005	4,161						54
55								55
56 Sewer Replacement	2006	13,522						56
57 A/C unit	2006	5,660						57
58 Resident Room Carpet	2006	11,370						58
59 Parking Lot Resurface	2006	47,908						59
60 Remodel Dinning Room	2006	4,854						60
61 Fire Alarm Panel	2006	531						61
62 Capital Report Adj	2006	(5,385)						62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 4,264,186	\$ 180,894		\$ 195,257	\$ 14,363	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,264,186	\$ 180,894		\$ 195,257	\$ 14,363	\$	1
2	Fire alarm	2007	44,843						2
3	HVAC	2007	12,000						3
4	Secire Care System	2007	9,092						4
5	Carpet	2007	13,896						5
6	Roof	2007	16,120						6
7									7
8									8
9	A/C Units	2008	7,182						9
10	Remodel Medicare Rooms - Paint	2008	5,392						10
11	Plumbing	2008	6,634						11
12	Parking Lot Resurface	2008	48,871						12
13	Roof	2008	4,492						13
14	Water Heater	2008	4,275						14
15									15
16									16
17	Water Heater	2009	9,128						17
18	Nurse Call & phone system	2009	279,962						18
19									19
20	The following items relate to the rehab of all wings, resident rooms and central								20
21	common area spaces performed by DS Renovations, LLC								21
22	General Conditions & Demolition	2009	77,349						22
23	Carpentry & Millwork	2009	248,504						23
24	Acoustical Ceiling & Flooring	2009	71,696						24
25	Painting	2009	93,983						25
26	Plumbing	2009	42,683						26
27	Electrical	2009	50,534						27
28	Design and layout	2009	30,556						28
29	Project Materials	2009	145,671						29
30	Telephone cables, ceiling tile & kick plates	2009	8,500						30
31	Nurse Station Modifications	2009	3,410						31
32	Ceiling tiles	2009	3,923						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,502,882	\$ 180,894		\$ 195,257	\$ 14,363	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,502,882	\$ 180,894		\$ 195,257	\$ 14,363	\$	1
2									2
3	Light fixtures	2009	3,179						3
4	The following items relate to the rehab of all wings, resident rooms and central								4
5	common area spaces performed by DS Renovations, LLC								5
6									6
7	Soft Goods, asbestos removal and materials	2010	217,391						7
8	4 ton trane unit	2010	10,684						8
9	gutters	2010	15,000						9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,749,136	\$ 180,894		\$ 195,257	\$ 14,363	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 5,749,136	\$ 180,894		\$ 195,257	\$ 14,363	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,749,136	\$ 180,894		\$ 195,257	\$ 14,363	\$	34

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

Facility Name & ID Number Heritage Manor-Pana

0048884

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	\$ 646,989	\$ 54,244	\$ 54,244	\$		\$	71
72	Current Year Purchases	349,263						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 996,252	\$ 54,244	\$ 54,244	\$		\$	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)	\$ 6,796,443	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 235,138	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 249,501	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,363	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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-Pana

STATE OF ILLINOIS
0048884

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	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2011	\$ _____
13.	_____ /2012	\$ _____
14.	_____ /2013	\$ _____

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: \$ 26,265 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		Contract	Total
		1	2		
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		302		302
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 302	\$	\$ 302
10	SUM OF line 9, col. 1 and 2 (e)	\$ 302			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
					Units	Cost								
1	Licensed Occupational Therapist		hrs	\$				\$ 266,808				\$ 266,808	1	
2	Licensed Speech and Language Development Therapist		hrs					153,349				153,349	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist		hrs					316,428	1,820			318,248	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						395,059			395,059	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	Other (specify):							66,279				66,279	13	
14	TOTAL			\$				\$ 802,864	\$ 396,879			\$ 1,199,743	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-Pana# 0048884Report 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	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 5,435	\$	1
2	Cash-Patient Deposits	12,027		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	508,870		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,753		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	125,151		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 665,236	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 665,236	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 221,080	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,027		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	320,004		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,335		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 581,446	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 581,446	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 83,790	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 665,236	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (495,388)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (495,388)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	\$ 579,178	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 579,178	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 83,790	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Pana# 0048884Report Period Beginning: 1-01-10

Ending:

12-31-10**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,006,908	1
2	Discounts and Allowances for all Levels	(3,200,309)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,806,599	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,670,803	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,670,803	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3,055	12
13	Barber and Beauty Care	24,595	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	689,518	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	14,435	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 731,603	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,610	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,610	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,217,615	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,076,138	31
32	Health Care	3,444,707	32
33	General Administration	1,397,242	33
B. Capital Expense			
34	Ownership	698,632	34
C. Ancillary Expense			
35	Special Cost Centers	21,718	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,638,437	40
41	Income before Income Taxes (line 30 minus line 40)**	579,178	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 579,178	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-Pana

0048884

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	1,890	2,080	\$ 68,179	\$ 32.78	1
2	Assistant Director of Nursing	2,999	3,439	63,352	18.42	2
3	Registered Nurses	6,792	7,089	182,278	25.71	3
4	Licensed Practical Nurses	18,524	19,951	389,315	19.51	4
5	CNAs & Orderlies	101,419	108,410	1,246,485	11.50	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,817	3,123	38,969	12.48	8
9	Activity Director					9
10	Activity Assistants	4,031	4,501	55,162	12.26	10
11	Social Service Workers	4,403	5,145	72,539	14.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,484	23,744	251,212	10.58	15
16	Dishwashers					16
17	Maintenance Workers	5,360	5,888	88,252	14.99	17
18	Housekeepers	11,929	12,528	96,337	7.69	18
19	Laundry	4,141	4,585	67,981	14.83	19
20	Administrator	1,900	2,080	102,794	49.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,268	8,669	186,018	21.46	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)	194,957	211,232	\$ 2,908,873 *	\$ 13.77	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		8,400		36
37	Medical Records Consultant		11,156		37
38	Nurse Consultant				38
39	Pharmacist Consultant		9,060		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		3,210		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 31,826		49

C. CONTRACT NURSES

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

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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Heritage Manor-Pana

0048884

Report Period Beginning: 1-01-10

Ending: 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 Pana 51533 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 82,673
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. \$ 2,289
- (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.