

		FOR BHF USE					

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH Facility ID Number:** 0038364

**Facility Name:** Heritage Manor-Peru

**Address:** 1301 - 21st Street Peru 61354  
 Number City Zip Code

**County:** LaSalle

**Telephone Number:** ( 815 ) 223-4901 Fax # ( )

**HFS ID Number:** 370909086013

**Date of Initial License for Current Owners:** 1965

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Craig Ater **Telephone Number:** ( 309 ) 823-7135

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Craig L. Ater</u>	
	(Title) <u>Senior V.P. &amp; CFO</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>( )</u> Fax # <u>( )</u>	
	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630	

Facility Name & ID Number Heritage Manor-Peru

# 0038364 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	129	Skilled (SNF)	129	47,085	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	129	TOTALS	129	47,085	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	25,137	9,889	7,461	42,487	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	25,137	9,889	7,461	42,487	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.23%

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 1965

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 7,461

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Heritage Manor-Peru # 0038364 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	256,356	15,685		272,041		272,041	5,694	277,735			1
2	Food Purchase		173,240		173,240		173,240		173,240			2
3	Housekeeping	102,470	27,085		129,555		129,555	6	129,561			3
4	Laundry	72,654	17,304		89,958		89,958		89,958			4
5	Heat and Other Utilities			137,139	137,139		137,139	1,797	138,936			5
6	Maintenance	115,922	46,758	26,889	189,569		189,569	15,060	204,629			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	547,402	280,072	164,028	991,502		991,502	22,557	1,014,059			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			6,894	6,894		6,894		6,894			9
10	Nursing and Medical Records	1,949,358	149,768	7,973	2,107,099		2,107,099		2,107,099			10
10a	Therapy		355,423	431,312	786,735	(544,298)	242,437	177,281	419,718			10a
11	Activities	109,041	4,162		113,203		113,203		113,203			11
12	Social Services	49,036	114	2,200	51,350		51,350		51,350			12
13	CNA Training							2,024	2,024			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,107,435	509,467	448,379	3,065,281	(544,298)	2,520,983	179,305	2,700,288			16
	<b>C. General Administration</b>											
17	Administrative	85,073			85,073		85,073	87,298	172,371			17
18	Directors Fees							6,481	6,481			18
19	Professional Services			394,985	394,985		394,985	(376,979)	18,006			19
20	Dues, Fees, Subscriptions & Promotions			115,664	115,664	(70,628)	45,036	(25,260)	19,776			20
21	Clerical & General Office Expenses	152,726	17,857	26,083	196,666		196,666	180,191	376,857			21
22	Employee Benefits & Payroll Taxes			661,276	661,276		661,276	46,900	708,176			22
23	Inservice Training & Education			1,037	1,037		1,037	1,519	2,556			23
24	Travel and Seminar			11,177	11,177		11,177	(9,178)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			86,063	86,063		86,063	2,299	88,362			26
27	Other (specify):*			975	975		975	(975)				27
28	<b>TOTAL General Administration</b>	237,799	17,857	1,297,260	1,552,916	(70,628)	1,482,288	(87,704)	1,394,584			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,892,636	807,396	1,909,667	5,609,699	(614,926)	4,994,773	114,158	5,108,931			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-Peru #0038364 Report Period Beginning: 01/01/05 Ending: 12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			112,041	112,041		112,041	15,282	127,323			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			130,498	130,498		130,498	26,149	156,647			32
33	Real Estate Taxes			43,317	43,317		43,317		43,317			33
34	Rent-Facility & Grounds							7,818	7,818			34
35	Rent-Equipment & Vehicles			7,422	7,422		7,422	(1,305)	6,117			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			293,278	293,278		293,278	47,944	341,222			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					544,298	544,298		544,298			39
40	Barber and Beauty Shops		30	16,469	16,499		16,499		16,499			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					70,628	70,628		70,628			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		30	16,469	16,499	614,926	631,425		631,425			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,892,636	807,426	2,219,414	5,919,476		5,919,476	162,102	6,081,578			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-Peru

# 0038364

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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	OHF 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	(3,285)	35		5
6	Rented Facility Space	(75)	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	(456)	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)		24		16
17	Non-Care Related Fees	(620)	20		17
18	Fines and Penalties				18
19	Entertainment	(21,189)	24		19
20	Contributions	(975)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(20,653)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(30,120)	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		23		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (77,373)		\$	30

OHF 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)	239,475		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 239,475		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 162,102		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Heritage Manor-Peru

ID# 0038364

Report Period Beginning: 01/01/05

Ending: 12/31/05

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		(3,285)	35
6		(75)	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(620)	20
18			18
19			24
20		(975)	27
21			21
22		(20,653)	19
23			23
24		0	27
25		(30,120)	20
26			26
27			27
28			28
29		0	23
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(55,728)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Peru# 0038364

Report Period Beginning:

01/01/05

Ending:

12/31/05**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	5,694	0	0	0	0	0	0	0	0	5,694	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	6	0	0	0	0	0	0	0	0	6	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,797	0	0	0	0	0	0	0	0	1,797	5
6	Maintenance	0	0	15,060	0	0	0	0	0	0	0	0	15,060	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	22,557	0	0	0	0	0	0	0	0	22,557	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	177,281	0	0	0	0	0	0	0	0	0	177,281	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	2,024	0	0	0	0	0	0	0	0	2,024	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	177,281	2,024	0	0	0	0	0	0	0	0	179,305	16
	<b>C. General Administration</b>													
17	Administrative	0	0	87,298	0	0	0	0	0	0	0	0	87,298	17
18	Directors Fees	0	0	6,481	0	0	0	0	0	0	0	0	6,481	18
19	Professional Services	(20,653)	(374,332)	18,006	0	0	0	0	0	0	0	0	(376,979)	19
20	Fees, Subscriptions & Promotions	(30,740)	0	5,480	0	0	0	0	0	0	0	0	(25,260)	20
21	Clerical & General Office Expenses	0	0	180,191	0	0	0	0	0	0	0	0	180,191	21
22	Employee Benefits & Payroll Taxes	0	0	46,900	0	0	0	0	0	0	0	0	46,900	22
23	Inservice Training & Education	0	0	1,519	0	0	0	0	0	0	0	0	1,519	23
24	Travel and Seminar	(21,189)	0	12,011	0	0	0	0	0	0	0	0	(9,178)	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	2,299	0	0	0	0	0	0	0	0	2,299	26
27	Other (specify):*	(975)	0	0	0	0	0	0	0	0	0	0	(975)	27
28	<b>TOTAL General Administration</b>	(73,557)	(374,332)	360,185	0	0	0	0	0	0	0	0	(87,704)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(73,557)	(197,051)	384,766	0	0	0	0	0	0	0	0	114,158	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Peru

# 0038364

Report Period Beginning:

01/01/05 Ending:

12/31/05

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	0	0	15,282	0	0	0	0	0	0	0	15,282	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(456)	0	0	26,605	0	0	0	0	0	0	0	26,149	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(75)	0	0	7,893	0	0	0	0	0	0	0	7,818	34
35	Rent-Equipment & Vehicles	(3,285)	0	0	1,980	0	0	0	0	0	0	0	(1,305)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,816)</b>	<b>0</b>	<b>0</b>	<b>51,760</b>	<b>0</b>	<b>47,944</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>(77,373)</b>	<b>(197,051)</b>	<b>384,766</b>	<b>51,760</b>	<b>0</b>	<b>162,102</b>	<b>45</b>						

Facility Name & ID Number Heritage Manor-Peru

# 0038364

Report Period Beginning:

01/01/05

Ending:

12/31/05

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V	10a Adjustment for Related Organization					
3	V						
4	V	19 Adjustment for Related Organization	374,332	Heritage Enterprises, Inc.	100.00%		(374,332)
5	V						
6	V	10a Adjustment for Related Organization	353,976	GreenTree Pharmacy	100.00%	531,257	177,281
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 728,308			\$ 531,257	\$ * (197,051)

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

Facility Name & ID Number Heritage Manor-Peru # 0038364 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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 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)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 5,694	\$ 5,694	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				6	6	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,797	1,797	19
20	V	6 Maintenance				15,060	15,060	20
21	V	7 Other				0		21
22	V	9 Medical Director				0		22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				0		24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				2,024	2,024	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				87,298	87,298	29
30	V	18 Directors Fees				6,481	6,481	30
31	V	19 Professional Services				18,006	18,006	31
32	V	20 Fees, Subscription, Promotions				5,480	5,480	32
33	V	21 Clerical & General Office Expenses				180,191	180,191	33
34	V	22 Employee Benefits & Payroll Taxes				46,900	46,900	34
35	V	23 Inservice Training & Education				1,519	1,519	35
36	V	24 Travel and Seminar				12,011	12,011	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				2,299	2,299	38
39	Total		\$			\$ 384,766	\$ * 384,766	39

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

Facility Name & ID Number Heritage Manor-Peru # 0038364 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	27	Other	\$	Heritage Enterprises, Inc.	100.00%	\$	0	15
16	V	30	Depreciation					15,282	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					26,605	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					7,893	20
21	V	35	Rent-Equipment & Vehicles					1,980	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	\$ * 51,760 39

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

Facility Name & ID Number Heritage Manor-Peru # 0038364 Report Period Beginning: 01/01/05 Ending: 12/31/05

## 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	Susie Jefferson	Director	Management	15.86				Salary/BOD	\$ 19,698	Ln 17 & 18	1
2	Estate of Tom Jefferson	Secretary	Management	16.21				Salary/BOD	0	Ln 17 & 18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	22,091	Ln 17 & 18	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Salary/BOD	13,154	Ln 17 & 18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	17,142	Ln 17 & 18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	8,458	Ln 17 & 18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	9,480	Ln 17 & 18	7
8	<b>Ben Hart</b>	<b>Vice President</b>	Management	3.20		40	100.00	Salary	3,756	Ln 17 & 18	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 93,779		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-Peru

# 0038364

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Heritage Enterprises  
 Street Address 115 W. Jefferson  
 City / State / Zip Code Bloomington, IL  
 Phone Number ( )  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,612	25	\$ 115,289	\$ 115,276	129	\$ 5,694	1
2	2	Food Purchase	Beds	2,612	25	7	0	129	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	129	6	3
4	4	Laundry	Beds	2,612	25	0	0	129	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	129	1,797	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	129	15,060	6
7	7	Other	Beds	2,612	25	0	0	129	0	7
8	9	Medical Director	Beds	2,612	25	0	0	129	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	129	0	9
10	11	Activities	Beds	2,612	25	0	0	129	0	10
11	12	Social Service	Beds	2,612	25	0	0	129	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	129	2,024	12
13	14	Program Transportation	Beds	2,612	25	0	0	129	0	13
14	15	Other	Beds	2,612	25	0	0	129	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,691,552	129	87,298	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	129	6,481	16
17	19	Professional Services	Beds	2,612	25	364,592	0	129	18,006	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	129	5,480	18
19	21	Clerical & General Office Expense	Beds	2,612	25	3,648,522	3,385,972	129	180,191	19
20	22	Employee Benefits & Payroll Tax	Beds	2,612	25	949,625	0	129	46,900	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	129	1,519	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	129	12,011	22
23	25	Other Admin. Staff Transportatio	Beds	2,612	25	0	0	129	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	129	2,299	24
25	TOTALS					\$ 7,790,758	\$ 5,312,886		\$ 384,766	25

Facility Name & ID Number Heritage Manor-Peru

# 0038364 Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	\$	129	\$	1
2	30	Depreciation	Beds	2,612	25	309,426	129	15,282	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25		129		3
4	32	Interest	Beds	2,612	25	538,695	129	26,605	4
5	33	Real Estate Taxes	Beds	2,612	25		129		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809	129	7,893	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093	129	1,980	7
8	36	Other	Beds	2,612	25		129		8
9	38	Medically Nec Transportation	Beds	2,612	25		129		9
10	39	Ancillary Service Centers	Beds	2,612	25		129		10
11	40	Barber and Beauty Shops	Beds	2,612	25		129		11
12	41	Coffee and Gift Shops	Beds	2,612	25		129		12
13	42	Other	Beds	2,612	25		129		13
14							129		14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,048,023	\$	\$ 51,760	25

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	LSsalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	\$	\$ 1,870,334	01/15/06	variable	\$ 100,467	1								
2	LSsalle National Bank		xx	Mortgage							8,318	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Central Office Allocation		xx	Working Capital							21,713	6								
7	Central Office Allocation		xx	Working Capital								7								
8												8								
9	<b>TOTAL Facility Related</b>						\$	\$ 1,870,334			\$ 130,498	9								
<b>B. Non-Facility Related*</b>																				
10	<b>Interest Income</b>										(456)	10								
11												11								
12	<b>Corporate Interest</b>										26,605	12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 26,149	14								
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 1,870,334			\$ 156,647	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

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 37,038	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.)		\$ 39,198	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 2,160	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 41,157	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.		\$ 43,317	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	35,604	8
	2001	35,343	9
	2002	35,050	10
	2003	33,453	11
	2004	35,728	12
<b>FOR OHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor-Peru COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0038364

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 2004 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 2004.

(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>17-09-312-013</u>	<u>Heritage Manor-Peru</u>	\$ <u>674.00</u>	\$ <u>674.00</u>
2. <u>17-09-312-014</u>	_____	\$ <u>38,524.00</u>	\$ <u>38,524.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>39,198.00</u>	\$ <u>39,198.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Heritage Manor-Peru

# 0038364 Report Period Beginning:

01/01/05 Ending:

12/31/05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 17,685 B. General Construction Type: Exterior brick/wood 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>40,500</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>40,500</u>	3

Facility Name &amp; ID Number Heritage Manor-Peru

# 0038364

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	129				\$ 391,963	\$		\$	\$	\$	4
5					325,283						5
6					153,474						6
7					677,402						7
8											8
		<b>Improvement Type**</b>									
9	1978 Improvements			1978							9
10	1979 Improvements			1979	6,059						10
11	1980 Improvements			1980	9,952						11
12	1981 Improvements			1981	28,648						12
13	1982 Improvements			1982	8,175						13
14	1983 Improvements			1983	39,938						14
15	1984 Improvements			1985	13,985						15
16	1985 Improvements			1986	19,793						16
17	1986 Improvements			1987	550						17
18	1988 Improvements			1988	22,120						18
19	1989 Improvements			1989	19,053						19
20	1990 Improvements			1990	25,453						20
21	1991 Improvements			1991	12,118						21
22	1992 Improvements			1992	19,157						22
23	1993 Improvements			1993	87,224						23
24	1994 Improvements			1994	43,270						24
25	1995 Improvements			1995	16,885						25
26	WATER SOFTNER			1996	8,377						26
27	AIR CONDITIONER			1996	4,550						27
28	LANDSCAPING			1996	97						28
29											29
30	INTERIOR REMODEL										30
31											31
32											32
33											33
34	C/O Allocation							15,282	15,282		34
35	Book Depreciation					85,117		85,117			35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Heritage Manor-Peru

# 0038364

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Interior Rehab---	1997	\$ 292,864	\$		\$	\$	\$	37
38	Parking Lot Sealer	1997	3,100						38
39	Commercial Disposal	1997	877						39
40									40
41	Water Heater	1998	4,308						41
42	A/C Repair	1998	6,457						42
43	Heater Repair	1998	954						43
44	Laundry Room Remodel	1998	1,450						44
45	Interior Rehab	1998	7,466						45
46									46
47	GFI Outlets	1999	3,420						47
48	Water Meter	1999	1,854						48
49	Roof Replacements	1999	80,498						49
50									50
51	Water Main Break Repair	2000	5,272						51
52	Door Monitor System	2000	9,852						52
53	Patio Improvements	2000	1,310						53
54									54
55	Lennox Condenser	2001	4,527						55
56	Water Heater	2001	3,708						56
57	Sewer Repair	2001	932						57
58									58
59	Sewer Repair	2002	1,267						59
60	Water Heater	2002	4,340						60
61	Ceiling Tiles	2002	110						61
62	Seal Parking Lot	2002	3,100						62
63	Door Lock	2002	1,370						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,372,562	\$ 85,117		\$ 100,399	\$ 15,282	\$	70

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

Facility Name &amp; ID Number Heritage Manor-Peru

# 0038364

Report Period Beginning:

01/01/05

Ending:

12/31/05

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,372,562	\$ 85,117		\$ 100,399	\$ 15,282	\$	1
2	Compressor	2003	844						2
3	Shower Room Remodel	2003	4,916						3
4	Back Flow Valve	2003	1,241						4
5	Parking Lot	2003	3,100						5
6	Generator	2003	2,749						6
7	Compressor	2003	939						7
8									8
9	Door Kickplates	2004	1,100						9
10	Repipe Water Heater	2004	1,730						10
11	Wallguards	2004	22,275						11
12	Heat Exchanger	2004	1,670						12
13	Carpet	2004	7,161						13
14									14
15	Ansul System	2005	1,685						15
16	Heat Exchanger	2005	1,800						16
17	Wall hvac	2005	959						17
18	Wallguards	2005	2,313						18
19	A/C condensing unit	2005	4,078						19
20	Exterior Door	2005	17,485						20
21	Solarium	2005	3,812						21
22	Lennox	2005	5,950						22
23	Shower Room Remodel	2005	5,588						23
24	Window Replacement	2005	55,419						24
25	Parking Lot Sealer	2005	3,940						25
26	Disposal	2005	1,303						26
27	Courtyard Door	2005	1,354						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,525,973	\$ 85,117		\$ 100,399	\$ 15,282	\$	34

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

Facility Name & ID Number Heritage Manor-Peru # 0038364 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	\$ 957,989	\$ 26,924	\$ 26,924	\$		\$ 843,920	71
72	Current Year Purchases	13,110						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 971,099	\$ 26,924	\$ 26,924	\$		\$ 843,920	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	3,537,572	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	112,041	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	127,323	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	15,282	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	843,920	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 6,117 Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
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	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

Facility Name &amp; ID Number

Heritage Manor-Peru

# 0038364

Report Period Beginning:

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Ending:

12/31/05

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 162,761	\$		\$ 162,761	1
2	Licensed Speech and Language Development Therapist		hrs			6,091			6,091	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			249,419	1,447		250,866	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				531,257		531,257	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					13,041			13,041	13
14	TOTAL			\$		\$ 431,312	\$ 532,704		\$ 964,016	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-Peru# 0038364Report Period Beginning: 01/01/05

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12/31/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(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	\$ 7,851	\$	1
2	Cash-Patient Deposits	25,449		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	799,703		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,438		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	5,545,593		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 6,394,034	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	2,331,985		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	943,455		16
17	Accumulated Depreciation (book methods)	(1,906,711)		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):	682		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,419,411	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,813,445	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 81,505	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,449		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	310,365		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,371		31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,157		32
33	Accrued Interest Payable	9,881		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 471,728	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,781,623		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,781,623	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,253,351	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 5,560,094	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 7,813,445	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,261,499	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,261,499	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	298,595	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)	\$ 298,595	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,560,094	24 *

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

Facility Name & ID Number Heritage Manor-Peru

# 0038364

Report Period Beginning: 01/01/05

Ending: 12/31/05

**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	\$ 6,289,020	1
2	Discounts and Allowances for all Levels	(1,935,164)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,353,856	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,239,509	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,239,509	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	(426)	12
13	Barber and Beauty Care	20,629	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	75	16
17	Sale of Drugs	603,972	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 624,250	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	456	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 456	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,218,071	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	991,502	31
32	Health Care	3,065,281	32
33	General Administration	1,552,916	33
<b>B. Capital Expense</b>			
34	Ownership	293,278	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	16,499	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>	\$ 5,919,476	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	298,595	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 298,595	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-Peru

# 0038364

Report Period Beginning:

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Ending:

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**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	2,000	2,160	\$ 52,918	\$ 24.50	1
2	Assistant Director of Nursing	2,520	2,800	55,225	19.72	2
3	Registered Nurses	17,398	19,148	365,014	19.06	3
4	Licensed Practical Nurses	21,075	23,530	410,825	17.46	4
5	CNAs & Orderlies	86,211	93,752	946,096	10.09	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,376	8,192	119,280	14.56	8
9	Activity Director					9
10	Activity Assistants	10,051	11,020	109,041	9.89	10
11	Social Service Workers	3,971	4,228	49,036	11.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,426	29,524	256,356	8.68	15
16	Dishwashers					16
17	Maintenance Workers	9,725	10,848	115,922	10.69	17
18	Housekeepers	12,113	13,038	102,470	7.86	18
19	Laundry	7,657	8,572	72,654	8.48	19
20	Administrator	1,900	2,080	85,073	40.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,905	11,138	152,726	13.71	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)	219,328	240,030	\$ 2,892,636 *	\$ 12.05	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		6,894		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,600		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		2,200		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,694		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





Facility Name &amp; ID Number Heritage Manor-Peru

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7 years
- (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 \_\_\_\_\_ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 70,628  
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. \$ 2,264
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes  
**g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available
- (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 \$2500, 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.



Name	Title	Function	Total Pay	Costed by Mgmt Fee	Total # Beds	Facility # Beds	Non-Nursing Home	Nursing Home	This Facility
### Susie Jefferson	Director	Management	418,245	418,245	2,612	129	3,471,750	71,391,262	19,698
### Tom Jefferson	Secretary	Management	0	0					0
### Craig Hart	Chairman	Management	469,049	469,049					22,091
### Cheryl Lowney	Executive Vice President	Management	279,290	279,290					13,154
### Steve Wannemache	President	Management	363,969	363,969					17,142
### Connie Hoselton	Sr Vice President	Management	179,584	179,584					8,458
### Craig Ater	Sr Vice President	Management	201,279	201,279					9,480
Ben Hart			79,758	79,758					3,756
13			1,991,174	1,991,174					93,779

\* 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 homes(s) as well as the amount paid. This amount must be 0 ##### total salaries

\*\*This must include all forms of compensation paid by related entities and allocated to Schedule 0 total mgt fees