

Facility Name & ID Number Heritage Manor-Pana

0048884 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	23,221	10,273	7,330	40,824	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,221	10,273	7,330	40,824	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.07%

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 7,330

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Manor-Pana # 0048884 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	246,929	19,360		266,289		266,289	5,888	272,177		1
2	Food Purchase		235,633		235,633		235,633	2	235,635		2
3	Housekeeping	91,975	20,346		112,321		112,321		112,321		3
4	Laundry	68,013	24,581		92,594		92,594		92,594		4
5	Heat and Other Utilities			140,606	140,606		140,606	3,016	143,622		5
6	Maintenance	103,416	50,994	34,796	189,206		189,206	30,064	219,270		6
7	Other (specify):*										7
8	TOTAL General Services	510,333	350,914	175,402	1,036,649		1,036,649	38,970	1,075,619		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400	2,926	11,326		9
10	Nursing and Medical Records	1,974,188	116,891	17,838	2,108,917		2,108,917		2,108,917		10
10a	Therapy		352,624	784,470	1,137,094	(399,468)	737,626	301,263	1,038,889		10a
11	Activities	54,086	1,115		55,201		55,201	1,311	56,512		11
12	Social Services	76,996		3,210	80,206		80,206		80,206		12
13	CNA Training		130		130		130	2,142	2,272		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,105,270	470,760	813,918	3,389,948	(399,468)	2,990,480	307,642	3,298,122		16
	C. General Administration										
17	Administrative	99,597			99,597		99,597		99,597		17
18	Directors Fees										18
19	Professional Services			277,980	277,980		277,980	(259,514)	18,466		19
20	Dues, Fees, Subscriptions & Promotions			109,585	109,585	(82,673)	26,912	(2,267)	24,645		20
21	Clerical & General Office Expenses	144,350	32,940	7,547	184,837		184,837	370,902	555,739		21
22	Employee Benefits & Payroll Taxes			557,931	557,931		557,931	48,701	606,632		22
23	Inservice Training & Education			1,999	1,999		1,999	1,525	3,524		23
24	Travel and Seminar			1,999	1,999		1,999	13,697	15,696		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,546	67,546		67,546	16,273	83,819		26
27	Other (specify):*			26,573	26,573		26,573	(26,349)	224		27
28	TOTAL General Administration	243,947	32,940	1,051,160	1,328,047	(82,673)	1,245,374	162,968	1,408,342		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,859,550	854,614	2,040,480	5,754,644	(482,141)	5,272,503	509,580	5,782,083		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

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							198,164	198,164			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,724	17,724		17,724	172,029	189,753			32
33	Real Estate Taxes							67,555	67,555			33
34	Rent-Facility & Grounds			661,380	661,380		661,380	(652,011)	9,369			34
35	Rent-Equipment & Vehicles			22,579	22,579		22,579	2,488	25,067			35
36	Other (specify):*											36
37	TOTAL Ownership			701,683	701,683		701,683	(211,775)	489,908			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					399,468	399,468		399,468			39
40	Barber and Beauty Shops			22,176	22,176		22,176		22,176			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			22,176	22,176	482,141	504,317		504,317			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,859,550	854,614	2,764,339	6,478,503		6,478,503	297,805	6,776,308			45

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

Heritage Manor-Pana

ID# 0048884

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(835)	20	17
18				18
19			24	19
20		(2,349)	27	20
21				21
22		(4,263)	19	22
23				23
24		(24,000)	27	24
25		(13,451)	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	(44,898)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Pana# 0048884

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	5,888	0	0	0	0	0	0	0	0	5,888	1
2	Food Purchase	0	0	2	0	0	0	0	0	0	0	0	2	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	3,016	0	0	0	0	0	0	0	0	3,016	5
6	Maintenance	0	0	30,064	0	0	0	0	0	0	0	0	30,064	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	38,970	0	38,970	8							
	B. Health Care and Programs													
9	Medical Director	0	0	2,926	0	0	0	0	0	0	0	0	2,926	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	301,263	0	0	0	0	0	0	0	0	0	301,263	10a
11	Activities	0	0	1,311	0	0	0	0	0	0	0	0	1,311	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	2,142	0	0	0	0	0	0	0	0	2,142	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	301,263	6,379	0	307,642	16							
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,263)	(273,717)	18,466	0	0	0	0	0	0	0	0	(259,514)	19
20	Fees, Subscriptions & Promotions	(14,286)	0	12,019	0	0	0	0	0	0	0	0	(2,267)	20
21	Clerical & General Office Expenses	0	0	370,902	0	0	0	0	0	0	0	0	370,902	21
22	Employee Benefits & Payroll Taxes	0	0	48,701	0	0	0	0	0	0	0	0	48,701	22
23	Inservice Training & Education	0	0	1,525	0	0	0	0	0	0	0	0	1,525	23
24	Travel and Seminar	0	0	13,697	0	0	0	0	0	0	0	0	13,697	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	16,273	0	0	0	0	0	0	0	0	16,273	26
27	Other (specify):*	(26,349)	0	0	0	0	0	0	0	0	0	0	(26,349)	27
28	TOTAL General Administration	(44,898)	(273,717)	481,583	0	162,968	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(44,898)	27,546	526,932	0	509,580	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Pana# 0048884

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	183,844	0	14,320	0	0	0	0	0	0	0	198,164	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,089)	177,617	0	501	0	0	0	0	0	0	0	172,029	32
33	Real Estate Taxes	0	67,555	0	0	0	0	0	0	0	0	0	67,555	33
34	Rent-Facility & Grounds	0	(661,380)	0	9,369	0	0	0	0	0	0	0	(652,011)	34
35	Rent-Equipment & Vehicles	0	0	0	2,488	0	0	0	0	0	0	0	2,488	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,089)	(232,364)	0	26,678	0	(211,775)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(50,987)	(204,818)	526,932	26,678	0	0	0	0	0	0	0	297,805	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V	<u>10a Adjustment for Related Organization</u>		<u>GreenTree Pharmacy</u>	<u>0.00%</u>	<u>301,263</u>	<u>301,263</u>	2
3	V							3
4	V	<u>19 Adjustment for Related Organization</u>	<u>273,717</u>	<u>Heritage Operations Group, LLC</u>	<u>0.00%</u>		<u>(273,717)</u>	4
5	V							5
6	V	<u>34 Adjustment for Related Organization</u>	<u>661,380</u>	<u>Heritage Manor Real Estate, LLC</u>	<u>0.00%</u>		<u>(661,380)</u>	6
7	V	<u>33 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>67,555</u>	<u>67,555</u>	7
8	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>172,944</u>	<u>172,944</u>	8
9	V	<u>30 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>183,844</u>	<u>183,844</u>	9
10	V	<u>32 Adjustment for Related Organization</u>		<u>Heritage Manor Real Estate, LLC</u>		<u>4,673</u>	<u>4,673</u>	10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>935,097</u>			\$ <u>730,279</u>	\$ * <u>(204,818)</u>	14

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

Facility Name & ID Number

Heritage Manor-Pana

0048884

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	5,888	15	
16	V	2 Food Purchase						2	16	
17	V	3 Housekeeping						0	17	
18	V	4 Laundry						0	18	
19	V	5 Heat & Other Utilities						3,016	19	
20	V	6 Maintenance						30,064	20	
21	V	7 Other						0	21	
22	V	9 Medical Director						2,926	22	
23	V	10 Nursing & Medical Records						0	23	
24	V	11 Activities						1,311	24	
25	V	12 Social Service						0	25	
26	V	13 Nurse Aide Training						2,142	26	
27	V	14 Program Transportation						0	27	
28	V	15 Other						0	28	
29	V	17 Administrative						0	29	
30	V	18 Directors Fees						0	30	
31	V	19 Professional Services						18,466	31	
32	V	20 Fees, Subscription, Promotions						12,019	32	
33	V	21 Clerical & General Office Expenses						370,902	33	
34	V	22 Employee Benefits & Payroll Taxes						48,701	34	
35	V	23 Inservice Training & Education						1,525	35	
36	V	24 Travel and Seminar						13,697	36	
37	V	25 Other Admin. Staff Transportation						0	37	
38	V	26 Insurance-Prop.Liab.Malpract						16,273	38	
39	Total		\$			\$	0	\$ *	526,932	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$	Heritage Enterprises, Inc.	0.00%	\$	\$	0 15
16	V	30 Depreciation						14,320 16
17	V	31 Amortization of Pre-Op & Org						0 17
18	V	32 Interest						501 18
19	V	33 Real Estate Taxes						0 19
20	V	34 Rent-Facility & Grounds						9,369 20
21	V	35 Rent-Equipment & Vehicles						2,488 21
22	V	36 Other						0 22
23	V	38 Medically Nec Transportation						0 23
24	V	39 Ancillary Service Centers						0 24
25	V	40 Barber and Beauty Shops						0 25
26	V	41 Coffee and Gift Shops						0 26
27	V	42 Other						0 27
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$	\$	0 \$ * 26,678 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: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

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

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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	\$ 102,708	\$ 102,349	151	\$ 5,888	1
2	2	Food Purchase	Beds	2,634	25	29	0	151	2	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	52,602	0	151	3,016	5
6	6	Maintenance	Beds	2,634	25	524,427	74,572	151	30,064	6
7	7	Other	Beds	2,634	25	0	0	151	0	7
8	9	Medical Director	Beds	2,634	25	51,047	0	151	2,926	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	60,856	151	0	9
10	11	Activities	Beds	2,634	25	22,860	22,749	151	1,311	10
11	12	Social Service	Beds	2,634	25	0	0	151	0	11
12	13	Nurse Aide Training	Beds	2,634	25	37,362	37,034	151	2,142	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	0	0	151	0	15
16	18	Directors Fees	Beds	2,634	25	0	0	151	0	16
17	19	Professional Services	Beds	2,634	25	322,118	0	151	18,466	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	209,651	0	151	12,019	18
19	21	Clerical & General Office Expense	Beds	2,634	25	6,469,900	6,230,337	151	370,902	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	849,520	0	151	48,701	20
21	23	Inservice Training & Education	Beds	2,634	25	26,602	0	151	1,525	21
22	24	Travel and Seminar	Beds	2,634	25	238,931	0	151	13,697	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	283,859	0	151	16,273	24
25	TOTALS					\$ 9,191,616	\$ 6,527,897		\$ 526,932	25

Facility Name & ID Number Heritage Manor-Pana

0048884

Report Period Beginning:

01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,634	25	\$	151	\$	1
2	30	Depreciation	Beds	2,634	25	249,793	151	14,320	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25		151		3
4	32	Interest	Beds	2,634	25	8,747	151	501	4
5	33	Real Estate Taxes	Beds	2,634	25		151		5
6	34	Rent-Facility & Grounds	Beds	2,634	25	163,432	151	9,369	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	43,399	151	2,488	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					\$ 465,371	\$	\$ 26,678	25

Facility Name & ID Number

Heritage Manor-Pana

0048884

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America		xx	Mortgage			\$	\$ 4,322,458	03/11	variable	\$ 170,917	1							
2	Bank of America		xx	Loan Fees							4,673	2							
3	Alpha Bank		xx	Van				22,130			2,027	3							
4												4							
5												5							
Working Capital																			
6	Bank of America		xx	Accounts Receivable							17,724	6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$ 4,344,588			\$ 195,341	9							
B. Non-Facility Related*																			
10	Interest Income										(6,089)	10							
11	Allocated Corporate										501	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (5,588)	14							
15	TOTALS (line 9+line14)						\$	\$ 4,344,588			\$ 189,753	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line #

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

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

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and			
1. Real Estate Tax accrual used on 2008 report.		\$			1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	67,555		2
3. Under or (over) accrual (line 2 minus line 1).		\$	67,555		3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (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.		\$	67,555		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2004	57,719			8
	2005	67,680			9
	2006	67,830			10
	2007	66,523			11
	2008	67,555			12
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2008	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Heritage Manor-Pana

0048884

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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:

	1	2	3	4	
A. Land.	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:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	151				\$ 3,943,054	\$		\$	\$	\$
5										
6										
7										
8										
	Improvement Type**									
9	Smoke Detectors		1997		1,113					
10										
11	Seal BlackTop/Parking Lot		1996		2,680					
12	Heritage Manor Sign		1996		2,192					
13	Laundry Room Central A/C		1996		3,019					
14										
15	Generator Repair		1998		1,559					
16	Roof		1998		26,420					
17										
18	roof		1999		113,936					
19										
20	Heat / Cool Unit		2000		1,170					
21	Roof Repair Walkway		2000		1,715					
22										
23										
24	Tile Floor		2001		1,646					
25	Heat/Cool Unit		2001		1,180					
26										
27	Day Room Carpet		2002		1,225					
28	Hot Water Heater		2002		2,224					
29	Sewar repair		2002		1,965					
30										
31										
32										
33	C/O Allocation									
34	Book Depreciation							14,320	14,320	
35						149,640		149,640		1,510,880
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Pana

0048884

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Sealcoat Parking Lot	2003	\$ 3,338	\$		\$	\$	\$	37
38	A/C unit	2003	1,153						38
39	Key Service Unit	2003	1,063						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	Underfloor 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									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,270,634	\$ 149,640		\$ 163,960	\$ 14,320	\$ 1,510,880	70

**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:

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

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,270,634	\$ 149,640		\$ 163,960	\$ 14,320	\$ 1,510,880	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	Asbestos Sample	2007	283						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								
21	common area spaces performed by DS Renovations, LLC								
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)		\$ 5,509,613	\$ 149,640		\$ 163,960	\$ 14,320	\$ 1,510,880	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	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		\$ 5,509,613	\$ 149,640		\$ 163,960	\$ 14,320	\$ 1,510,880	1
2								2
3	2009	3,179						3
4								4
5								5
6								6
7								7
8								8
9								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		\$ 5,512,792	\$ 149,640		\$ 163,960	\$ 14,320	\$ 1,510,880	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 632,235	\$ 34,204	\$ 34,204	\$		\$ 519,908	71
72	Current Year Purchases	14,754						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 646,989	\$ 34,204	\$ 34,204	\$		\$ 519,908	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)	\$ 6,210,836	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 183,844	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 198,164	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,320	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,030,788	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 22,579 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		130		130
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	\$	\$ 130	\$	\$ 130
10	SUM OF line 9, col. 1 and 2 (e)	\$	130		

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	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	\$		\$ 259,382	\$		\$ 259,382	1
2	Licensed Speech and Language Development Therapist		hrs			171,732			171,732	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			304,993	1,519		306,512	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				351,105		351,105	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____					48,363			48,363	13
14	TOTAL			\$		\$ 784,470	\$ 352,624		\$ 1,137,094	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: 01/01/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 6,430	\$	1
2	Cash-Patient Deposits	18,832		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	794,459		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,261		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(200,300)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 635,682	\$	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)	\$ 635,682	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 151,998	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,832		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	296,395		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,188		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)	\$ 497,413	\$	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)	\$ 497,413	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 138,269	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 635,682	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (641,342)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (641,342)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	779,611	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)	\$ 779,611	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)	\$ 138,269	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Pana# 0048884Report Period Beginning: 01/01/2009Ending: 12/31/2009**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,134,421	1
2	Discounts and Allowances for all Levels	(3,764,810)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,369,611	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,198,899	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,198,899	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	7,048	12
13	Barber and Beauty Care	24,122	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	652,342	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 683,512	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,092	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,092	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			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)	\$ 7,258,114	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,036,649	31
32	Health Care	3,389,948	32
33	General Administration	1,328,047	33
B. Capital Expense			
34	Ownership	701,683	34
C. Ancillary Expense			
35	Special Cost Centers	22,176	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)*	\$ 6,478,503	40
41	Income before Income Taxes (line 30 minus line 40)**	779,611	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 779,611	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: **01/01/2009**

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,890	2,080	\$ 67,617	\$ 32.51	1
2	Assistant Director of Nursing	2,999	3,439	69,542	20.22	2
3	Registered Nurses	6,792	7,089	173,809	24.52	3
4	Licensed Practical Nurses	18,524	19,951	381,691	19.13	4
5	CNAs & Orderlies	101,419	108,410	1,234,842	11.39	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,817	3,123	46,687	14.95	8
9	Activity Director					9
10	Activity Assistants	4,031	4,501	54,086	12.02	10
11	Social Service Workers	4,403	5,145	76,996	14.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,484	23,744	246,929	10.40	15
16	Dishwashers					16
17	Maintenance Workers	5,360	5,888	103,416	17.56	17
18	Housekeepers	11,929	12,528	91,975	7.34	18
19	Laundry	4,141	4,585	68,013	14.83	19
20	Administrator	1,900	2,080	99,597	47.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,268	8,669	144,350	16.65	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	\$ 2,859,550 *	\$ 13.54	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		10,144		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,530		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)		\$ 26,284		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 & ID Number Heritage Manor-Pana# 0048884Report Period Beginning: 01/01/2009 Ending: 12/31/2009**XX. GENERAL INFORMATION:**

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