



Facility Name & ID Number Heritage Manor-Peru

# 0048090 Report Period Beginning: 1-01-10 Ending: 12-31-10

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	24,515	6,323	3,897	34,735	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,515	6,323	3,897	34,735	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.77%**

**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 2006

**J. Was the facility purchased or leased after January 1, 1978?**

YES  Date \_\_\_\_\_ NO

**K. Was the facility certified for Medicare during the reporting year?**

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 3,897

Medicare Intermediary WPS

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name &amp; ID Number

Heritage Manor-Peru

# 0048090

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	219,106	16,944		236,050		236,050	5,141	241,191		1
2	Food Purchase		221,588		221,588		221,588	(1,214)	220,374		2
3	Housekeeping	84,657	27,412		112,069		112,069		112,069		3
4	Laundry	64,736	9,324		74,060		74,060		74,060		4
5	Heat and Other Utilities			106,061	106,061		106,061	2,222	108,283		5
6	Maintenance	120,847	66,519	43,871	231,237		231,237	15,307	246,544		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	489,346	341,787	149,932	981,065		981,065	21,456	1,002,521		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000	3,777	9,777		9
10	Nursing and Medical Records	1,984,058	144,647	27,199	2,155,904		2,155,904		2,155,904		10
10a	Therapy		183,996	419,677	603,673	(190,708)	412,965	255,780	668,745		10a
11	Activities	112,664	844		113,508		113,508	5	113,513		11
12	Social Services	36,583	1,344	2,576	40,503		40,503		40,503		12
13	CNA Training							1,705	1,705		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,133,305	330,831	455,452	2,919,588	(190,708)	2,728,880	261,267	2,990,147		16
	<b>C. General Administration</b>										
17	Administrative	99,783			99,783		99,783	109,206	208,989		17
18	Directors Fees										18
19	Professional Services			263,895	263,895		263,895	(241,598)	22,297		19
20	Dues, Fees, Subscriptions & Promotions			101,454	101,454	(70,628)	30,826	(5,712)	25,114		20
21	Clerical & General Office Expenses	211,793	20,270	9,365	241,428		241,428	223,544	464,972		21
22	Employee Benefits & Payroll Taxes			605,829	605,829		605,829	41,018	646,847		22
23	Inservice Training & Education			4,306	4,306		4,306	(2,307)	1,999		23
24	Travel and Seminar			1,045	1,045		1,045	954	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			56,165	56,165		56,165	14,673	70,838		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	311,576	20,270	1,042,059	1,373,905	(70,628)	1,303,277	139,778	1,443,055		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,934,227	692,888	1,647,443	5,274,558	(261,336)	5,013,222	422,501	5,435,723		29

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

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

Facility Name &amp; ID Number

Heritage Manor-Peru

#0048090

Report Period Beginning:

1-01-10

Ending:

12-31-10

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							257,857	257,857			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,388	9,388		9,388	160,836	170,224			32
33	Real Estate Taxes							46,259	46,259			33
34	Rent-Facility & Grounds			565,020	565,020		565,020	(556,475)	8,545			34
35	Rent-Equipment & Vehicles			8,736	8,736		8,736	1,567	10,303			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			583,144	583,144		583,144	(89,956)	493,188			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					190,708	190,708		190,708			39
40	Barber and Beauty Shops			17,686	17,686		17,686		17,686			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>			17,686	17,686	261,336	279,022		279,022			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,934,227	692,888	2,248,273	5,875,388		5,875,388	332,545	6,207,933			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

# 0048090

Report Period Beginning:

1-01-10

Ending:

12-31-10

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer-ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		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	(6,123)	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)	(2,787)	23		16
17	Non-Care Related Fees	(1,227)	20		17
18	Fines and Penalties				18
19	Entertainment	(9,349)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,300)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(17,708)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (42,494)		\$	30

<b>BHF USE ONLY</b>							
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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	375,039		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 375,039		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 332,545		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.**

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

Heritage Manor-Peru

ID# 0048090

Report Period Beginning: 1-01-10

Ending: 12-31-10

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(1,227)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(5,300)	19	22
23				23
24		0	27	24
25		(17,708)	20	25
26				26
27				27
28				28
29		0	33	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(24,235)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Peru

# 0048090 Report Period Beginning:

1-01-10

Ending:

12-31-10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	5,141	0	0	0	0	0	0	0	0	5,141	1
2	Food Purchase	0	0	(1,214)	0	0	0	0	0	0	0	0	(1,214)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,222	0	0	0	0	0	0	0	0	2,222	5
6	Maintenance	0	0	15,307	0	0	0	0	0	0	0	0	15,307	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>0</b>	<b>21,456</b>	<b>0</b>	<b>21,456</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	3,777	0	0	0	0	0	0	0	0	3,777	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	255,780	0	0	0	0	0	0	0	0	0	255,780	10a
11	Activities	0	0	5	0	0	0	0	0	0	0	0	5	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,705	0	0	0	0	0	0	0	0	1,705	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>255,780</b>	<b>5,487</b>	<b>0</b>	<b>261,267</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	109,206	0	0	0	0	0	0	0	0	109,206	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,300)	(258,595)	22,297	0	0	0	0	0	0	0	0	(241,598)	19
20	Fees, Subscriptions & Promotions	(18,935)	0	13,223	0	0	0	0	0	0	0	0	(5,712)	20
21	Clerical & General Office Expenses	0	0	223,544	0	0	0	0	0	0	0	0	223,544	21
22	Employee Benefits & Payroll Taxes	0	0	41,018	0	0	0	0	0	0	0	0	41,018	22
23	Inservice Training & Education	(2,787)	0	480	0	0	0	0	0	0	0	0	(2,307)	23
24	Travel and Seminar	(9,349)	0	10,303	0	0	0	0	0	0	0	0	954	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	14,673	0	0	0	0	0	0	0	0	14,673	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(36,371)</b>	<b>(258,595)</b>	<b>434,744</b>	<b>0</b>	<b>139,778</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(36,371)</b>	<b>(2,815)</b>	<b>461,687</b>	<b>0</b>	<b>422,501</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Peru# 0048090

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	245,587	0	12,270	0	0	0	0	0	0	0	257,857	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,123)	166,180	0	779	0	0	0	0	0	0	0	160,836	32
33	Real Estate Taxes	0	46,188	0	71	0	0	0	0	0	0	0	46,259	33
34	Rent-Facility & Grounds	0	(565,020)	0	8,545	0	0	0	0	0	0	0	(556,475)	34
35	Rent-Equipment & Vehicles	0	0	0	1,567	0	0	0	0	0	0	0	1,567	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(6,123)</b>	<b>(107,065)</b>	<b>0</b>	<b>23,232</b>	<b>0</b>	<b>(89,956)</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 (sum of lines 29, 37 &amp; 44)</b>	<b>(42,494)</b>	<b>(109,880)</b>	<b>461,687</b>	<b>23,232</b>	<b>0</b>	<b>332,545</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$		1
2	V	10a Adjustment for Related Organization		GreenTree Pharmacy	0.00%	255,780	255,780	2
3	V							3
4	V	19 Adjustment for Related Organization	258,595	Heritage Operations Group, LLC	0.00%		(258,595)	4
5	V							5
6	V	34 Adjustment for Related Organization	565,020	Heritage Manor Real Estate, LLC	0.00%		(565,020)	6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		46,188	46,188	7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		137,687	137,687	8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		245,587	245,587	9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		28,493	28,493	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 823,615			\$ 713,735	\$ * (109,880)	14

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

Facility Name &amp; ID Number

Heritage Manor-Peru

# 0048090

Report Period Beginning:

1-01-10

Ending:

12-31-10

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.		\$	\$ 5,141	15
16	V	2 Food Purchase					(1,214)	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					2,222	19
20	V	6 Maintenance					15,307	20
21	V	7 Other					0	21
22	V	9 Medical Director					3,777	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					5	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,705	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					109,206	29
30	V	18 Directors Fees					0	30
31	V	19 Professional Services					22,297	31
32	V	20 Fees, Subscription, Promotions					13,223	32
33	V	21 Clerical & General Office Expenses					223,544	33
34	V	22 Employee Benefits & Payroll Taxes					41,018	34
35	V	23 Inservice Training & Education					480	35
36	V	24 Travel and Seminar					10,303	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					14,673	38
39	Total		\$			\$	0	\$ * 461,687 39

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Enterprises, Inc.		\$	\$	0 15
16	V	30	Depreciation						12,270 16
17	V	31	Amortization of Pre-Op & Org						0 17
18	V	32	Interest						779 18
19	V	33	Real Estate Taxes						71 19
20	V	34	Rent-Facility & Grounds						8,545 20
21	V	35	Rent-Equipment & Vehicles						1,567 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	\$ * 23,232 39

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

Facility Name &amp; ID Number

Heritage Manor-Peru

#

0048090

Report Period Beginning:

1-01-10

Ending:

12-31-10

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					\$ 0	18/7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number

Heritage Manor-Peru

# 0048090

Report Period Beginning:

1-01-10

Ending: 12-31-10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 104,969	\$ 104,969	129	\$ 5,141	1
2	2	Food Purchase	Beds	2,634	25	(24,794)	0	129	(1,214)	2
3	3	Housekeeping	Beds	2,634	25	0	0	129	0	3
4	4	Laundry	Beds	2,634	25	0	0	129	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	45,364	0	129	2,222	5
6	6	Maintenance	Beds	2,634	25	312,555	75,007	129	15,307	6
7	7	Other	Beds	2,634	25	0	0	129	0	7
8	9	Medical Director	Beds	2,634	25	77,111	0	129	3,777	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	77,111	129	0	9
10	11	Activities	Beds	2,634	25	95	0	129	5	10
11	12	Social Service	Beds	2,634	25	0	0	129	0	11
12	13	Nurse Aide Training	Beds	2,634	25	34,804	0	129	1,705	12
13	14	Program Transportation	Beds	2,634	25	0	0	129	0	13
14	15	Other	Beds	2,634	25	0	0	129	0	14
15	17	Administrative	Beds	2,634	25	2,229,831	2,229,831	129	109,206	15
16	18	Directors Fees	Beds	2,634	25	0	0	129	0	16
17	19	Professional Services	Beds	2,634	25	455,276	0	129	22,297	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	269,994	0	129	13,223	18
19	21	Clerical & General Office Expens	Beds	2,634	25	4,564,447	4,163,572	129	223,544	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	837,533	0	129	41,018	20
21	23	Inservice Training & Education	Beds	2,634	25	9,793	0	129	480	21
22	24	Travel and Seminar	Beds	2,634	25	210,373	0	129	10,303	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	129	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	299,608	0	129	14,673	24
25	TOTALS					\$ 9,426,959	\$ 6,650,490		\$ 461,687	25

Facility Name & ID Number

Heritage Manor-Peru

# 0048090

Report Period Beginning:

1-01-10

Ending: 12-31-10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	27	Other	Beds	2,634	25	\$	\$	129	\$	1
2	30	Depreciation	Beds	2,634	25	250,538		129	12,270	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	25			129		3
4	32	Interest	Beds	2,634	25	15,900		129	779	4
5	33	Real Estate Taxes	Beds	2,634	25	1,448		129	71	5
6	34	Rent-Facility & Grounds	Beds	2,634	25	174,472		129	8,545	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	25	31,994		129	1,567	7
8	36	Other	Beds	2,634	25			129		8
9	38	Medically Nec Transportation	Beds	2,634	25			129		9
10	39	Ancillary Service Centers	Beds	2,634	25			129		10
11	40	Barber and Beauty Shops	Beds	2,634	25			129		11
12	41	Coffee and Gift Shops	Beds	2,634	25			129		12
13	42	Other	Beds	2,634	25			129		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 474,352	\$		\$ 23,232	25

Facility Name & ID Number

Heritage Manor-Peru

# 0048090

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Bank of America		xx	Mortgage			\$	\$ 3,418,664	3/2011	variable	\$	137,687						
2	Bank of America		xx	Loan Fees								28,493						
3																		
4																		
5																		
<b>Working Capital</b>																		
6	Bank of America		xx	Accounts Receivable								9,388						
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$ 3,418,664			\$	175,568						
<b>B. Non-Facility Related*</b>																		
10	Interest Income											(6,123)						
11	Allocated Corporate											779						
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	(5,344)						
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 3,418,664			\$	170,224						

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2009 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>46,188</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>46,188</b>	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>46,188</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	<b>43,317</b>	8
	2006	<b>57,458</b>	9
	2007	<b>42,621</b>	10
	2008	<b>44,117</b>	11
	2009	<b>46,188</b>	12

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

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

FACILITY NAME Heritage Manor-Peru COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048090

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

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

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

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>1709312013</u>	<u>nursing home</u>	\$ <u>2,266.00</u>	\$ <u>2,266.00</u>
2. <u>1709312014</u>	<u>_____</u>	\$ <u>43,922.00</u>	\$ <u>43,922.00</u>
3. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
4. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
5. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
6. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
7. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
8. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
9. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
10. <u>_____</u>	<u>_____</u>	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>46,188.00</u></u>	\$ <u><u>46,188.00</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number Heritage Manor-Peru

# 0048090 Report Period Beginning:

1-01-10 Ending:

12-31-10

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 25,183 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 40,500	1
2					2
3	TOTALS			\$ 40,500	3

Facility Name & ID Number Heritage Manor-Peru# 0048090

Report Period Beginning:

1-01-10

Ending:

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	129				\$ 391,963	\$		\$	\$	\$	4
5					325,293						5
6					153,474						6
7					677,402						7
8											8
	<b>Improvement Type**</b>										
9	1978 Improvements		1978		6,059						9
10	1979 Improvements		1979		9,952						10
11	1980 Improvements		1980		28,648						11
12	1981 Improvements		1981		8,175						12
13	1982 Improvements		1982		39,938						13
14	1983 Improvements		1983		13,985						14
15	1984 Improvements		1985		19,793						15
16	1985 Improvements		1986		550						16
17	1986 Improvements		1987		22,120						17
18	1988 Improvements		1988		19,053						18
19	1989 Improvements		1989		25,453						19
20	1990 Improvements		1990		12,118						20
21	1991 Improvements		1991		19,157						21
22	1992 Improvements		1992		87,224						22
23	1993 Improvements		1993		43,270						23
24	1994 Improvements		1994		16,885						24
25	1995 Improvements		1995		8,377						25
26	WATER SOFTNER		1996		4,550						26
27	AIR CONDITIONER		1996		97						27
28	LANDSCAPING		1996								28
29											29
30	INTERIOR REMODEL										30
31											31
32											32
33	C/O Allocation							12,270	12,270		33
34	Book Depreciation					177,884		177,884			34
35											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 & ID Number Heritage Manor-Peru# 0048090

Report Period Beginning:

1-01-10

Ending:

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Interior Rehab---	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)		\$ 2,372,572	\$ 177,884		\$ 190,154	\$ 12,270	\$	70

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

Facility Name & ID Number Heritage Manor-Peru# 0048090

Report Period Beginning:

1-01-10

Ending:

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,372,572	\$ 177,884		\$ 190,154	\$ 12,270		1
2	2003	844						2
3	2003	4,916						3
4	2003	1,241						4
5	2003	3,100						5
6	2003	2,749						6
7	2003	939						7
8								8
9	2004	1,100						9
10	2004	1,730						10
11	2004	22,275						11
12	2004	1,670						12
13	2004	7,161						13
14								14
15	2005	1,685						15
16	2005	1,800						16
17	2005	959						17
18	2005	2,313						18
19	2005	4,078						19
20	2005	17,485						20
21	2005	3,812						21
22	2005	5,950						22
23	2005	5,588						23
24	2005	55,419						24
25	2005	3,940						25
26	2005	1,303						26
27	2005	1,354						27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 2,525,983	\$ 177,884		\$ 190,154	\$ 12,270	\$	34

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

Facility Name & ID Number Heritage Manor-Peru# 0048090

Report Period Beginning:

1-01-10

Ending:

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,525,983	\$ 177,884		\$ 190,154	\$ 12,270	\$	1
2	<u>Code Alert</u>	2006	7,226						2
3	<u>Windows</u>	2006	876						3
4	<u>Exterior Door</u>	2006	2,620						4
5	<u>Chimney</u>	2006	6,250						5
6	<u>Boiler</u>	2006	3,002						6
7	<u>Garbage Disposal</u>	2006	1,072						7
8	<u>Sprinklers</u>	2006	34,076						8
9	<u>Heat Pump</u>	2006	1,073						9
10									10
11	<u>Sprinkler System</u>	2007	189,741						11
12	<u>Water Heater</u>	2007	11,400						12
13	<u>Sewer</u>	2007	3,394						13
14	<u>HVAC</u>	2007	70,422						14
15	<u>Gazebo</u>	2007	4,750						15
16	<u>PTAC Unit</u>	2007	2,720						16
17	<u>Wander Guard</u>	2007	3,129						17
18	<u>Dryer</u>	2007	4,068						18
19	<u>Condensor</u>	2007	14,928						19
20									20
21	<u>Water Main</u>	2008	30,831						21
22	<u>Resident Room Plumbing</u>	2008	12,661						22
23	<u>Parking Lot Repairs</u>	2008	5,221						23
24	<u>Water Softener</u>	2008	9,748						24
25	<u>Water Heater</u>	2008	9,120						25
26	<u>Nurse Call &amp; Phone system</u>	2009	263,840						26
27	<u>Water Pipe</u>	2009	16,750						27
28	<u>Condensing Unit</u>	2009	3,334						28
29									29
30	<u>Plumbing</u>	2009	4,295						30
31	<u>Concrete Ramp</u>	2009	3,150						31
32	<u>Water Heater</u>	2009	6,750						32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,252,430	\$ 177,884		\$ 190,154	\$ 12,270	\$	34

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

Facility Name & ID Number Heritage Manor-Peru# 0048090

Report Period Beginning:

1-01-10

Ending:

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,252,430	\$ 177,884		\$ 190,154	\$ 12,270		1
2								2
3								3
4	2009	89,600						4
5	2009	251,225						5
6	2009	150,757						6
7	2009	56,514						7
8	2009	30,679						8
9	2009	88,804						9
10	2009	43,648						10
11	2009	31,594						11
12								12
13	2009	12,958						13
14								14
15	2010	12,795						15
16	2010	31,701						16
17	2010	46,950						17
18								18
19	2010	41,507						19
20	2010	77,921						20
21	2010	29,947						21
22	2010	75,786						22
23	2010	27,465						23
24	2010	42,154						24
25	2010	21,347						25
26	2010	16,506						26
27	2010	45,238						27
28								28
29	2010	6,000						29
30	2010	19,170						30
31	2010	189,525						31
32	2010	54,725						32
33								33
34		\$ 4,746,946	\$ 177,884		\$ 190,154	\$ 12,270	\$	34

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

Facility Name & ID Number Heritage Manor-Peru

# 0048090

Report Period Beginning:

1-01-10

Ending:

12-31-10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,099,726	\$ 67,703	\$ 67,703	\$		\$	71
72	Current Year Purchases	401,080						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,500,806	\$ 67,703	\$ 67,703	\$		\$	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)	\$ 6,288,252	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 245,587	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 257,857	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,270	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number

Heritage Manor-Peru

# 0048090

Report Period Beginning:

1-01-10

Ending: 12-31-10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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

If NO, see instructions.

YES NO

Table with 8 columns: 1 Year Constructed, 2 Number of Beds, 3 Original Lease Date, 4 Rental Amount, 5 Total Years of Lease, 6 Total Years Renewal Option\*, 7. Rows include Original Building, Additions, and TOTAL.

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: \$ 8,736 Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

Table with 5 columns: 1 Use, 2 Model Year and Make, 3 Monthly Lease Payment, 4 Rental Expense for this Period, 5. Rows include 17, 18, 19, 20, and 21 TOTAL.

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

Table with 2 columns: Fiscal Year Ending, Annual Rent. Rows for 2011, 2012, and 2013.

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

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

Facility Name & ID Number

Heritage Manor-Peru

#

0048090

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 197,820	\$		\$ 197,820	1
2	Licensed Speech and Language Development Therapist		hrs			4,121			4,121	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			210,837	187		211,024	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				183,809		183,809	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					6,899			6,899	13
14	<b>TOTAL</b>			\$		\$ 419,677	\$ 183,996		\$ 603,673	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# 0048090Report Period Beginning: 1-01-10

Ending:

12-31-10

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 30,680	\$	1
2	Cash-Patient Deposits	21,273		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	190,987		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,996		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	163,977		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 423,913	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 423,913	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 155,871	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,273		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	231,521		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,193		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 440,858	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 440,858	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (16,945)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 423,913	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>88,744</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>88,744</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(105,689)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(105,689)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(16,945)</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,819,519	1
2	Discounts and Allowances for all Levels	(1,856,790)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,962,729</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,451,817	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,451,817</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,979	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	326,051	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 349,030</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	6,123	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 6,123</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Other</u>		28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,769,699</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	981,065	31
32	Health Care	2,919,588	32
33	General Administration	1,373,905	33
<b>B. Capital Expense</b>			
34	Ownership	583,144	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	17,686	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 5,875,388</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(105,689)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (105,689)</b>	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor-Peru

# 0048090

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,952	2,160	\$ 65,442	\$ 30.30	1
2	Assistant Director of Nursing	3,892	4,320	101,046	23.39	2
3	Registered Nurses	9,311	9,752	270,359	27.72	3
4	Licensed Practical Nurses	25,340	27,296	540,033	19.78	4
5	CNAs & Orderlies	79,197	85,717	911,167	10.63	5
6	CNA Trainees	250	250	0	0.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,482	6,064	96,011	15.83	8
9	Activity Director					9
10	Activity Assistants	9,872	10,815	112,664	10.42	10
11	Social Service Workers	2,102	2,190	36,583	16.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,469	24,254	219,106	9.03	15
16	Dishwashers					16
17	Maintenance Workers	9,888	10,467	120,847	11.55	17
18	Housekeepers	11,263	11,849	84,657	7.14	18
19	Laundry	5,105	5,585	64,736	11.59	19
20	Administrator	1,900	2,080	99,783	47.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,572	13,381	211,793	15.83	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)	198,595	216,180	\$ 2,934,227 *	\$ 13.57	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	6,000		36
37	Medical Records Consultant	6,884		37
38	Nurse Consultant			38
39	Pharmacist Consultant	7,740		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	2,576		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 23,200		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
<u>Caroline Daugherty</u>			\$ <u>99,783</u>	<u>Workers' Compensation Insurance</u>	\$ <u>81,280</u>	<u>IDPH License Fee</u>	\$ <u>0</u>		
				<u>Unemployment Compensation Insurance</u>	<u>25,488</u>	<u>Advertising: Employee Recruitment</u>	<u>1,177</u>		
				<u>FICA Taxes</u>	<u>224,468</u>	<u>Health Care Worker Background Check</u>			
				<u>Employee Health Insurance</u>	<u>248,359</u>	(Indicate # of checks performed _____)	<u>2,510</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>			
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>					
					<u>0</u>		<u>8,085</u>		
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <u>99,783</u>	<u>Other Benefits</u>	<u>26,234</u>	<u>Dues &amp; Subscriptions</u>	<u>8,861</u>		
(List each licensed administrator separately.)				<u>Central Office Allocation</u>	<u>41,018</u>	<u>License &amp; Fees</u>	<u>570</u>		
						<u>Central Office Allocation</u>	<u>13,223</u>		
						<u>Less: Public Relations Expense</u>	<u>(8,085)</u>		
						<u>Non-allowable advertising</u>	<u>(1,227)</u>		
						<u>Yellow page advertising</u>	( _____ )		
						<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	\$ <u>25,114</u>		
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$ _____	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>		
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount	
<b>B. Administrative - Other</b>			Amount				<u>Out-of-State Travel</u>	\$ _____	
Description			\$ _____						
							<u>In-State Travel</u>		
								<u>0</u>	
								<u>1,045</u>	
							<u>Seminar Expense</u>	<u>0</u>	
							<u>Central Office</u>	<u>954</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$ _____				<u>Entertainment Expense</u>	( _____ )	
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)		
<b>C. Professional Services</b>			Amount	<b>TOTAL</b>			<b>TOTAL</b>	\$ <u>1,999</u>	
Vendor/Payee	Type	Amount	\$ _____						
<u>Heritage Operations Group</u>	<u>Mgt Fee</u>	<u>258,595</u>							
<u>McQuellen Consulting</u>	<u>R/E appeals</u>	<u>0</u>							
<u>Legal adj to Zero</u>		<u>5,300</u>							
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <u>263,895</u>						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number Heritage Manor-Peru

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

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

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

Facility Name & ID Number Heritage Manor-Peru# 0048090

Report Period Beginning:

1-01-10

Ending:

12-31-10**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES x NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Heritage Manor Peru 38364 07/2006
- (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. \$ 45
- (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.