

Facility Name & ID Number Heritage Manor-Elgin

0038307 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	<u>94</u>	Skilled (SNF)	<u>94</u>	<u>34,310</u>	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	<u>94</u>	TOTALS	<u>94</u>	<u>34,310</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>22,496</u>	<u>4,955</u>	<u>2,958</u>	<u>30,409</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,496</u>	<u>4,955</u>	<u>2,958</u>	<u>30,409</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.63%

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 1989

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 2,958

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	223,205	25,038		248,243		248,243	4,767	253,010		1
2	Food Purchase		164,703		164,703		164,703	5	164,708		2
3	Housekeeping	98,007	29,866		127,873		127,873		127,873		3
4	Laundry	39,914	16,486		56,400		56,400		56,400		4
5	Heat and Other Utilities			105,904	105,904		105,904	1,280	107,184		5
6	Maintenance	96,981	47,170	44,774	188,925		188,925	11,735	200,660		6
7	Other (specify):*										7
8	TOTAL General Services	458,107	283,263	150,678	892,048		892,048	17,787	909,835		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000	1,757	7,757		9
10	Nursing and Medical Records	1,606,490	144,599	8,842	1,759,931		1,759,931		1,759,931		10
10a	Therapy		220,059	609,580	829,639	(404,672)	424,967	181,401	606,368		10a
11	Activities	77,622	4,737		82,359		82,359	1,253	83,612		11
12	Social Services	34,911		2,886	37,797		37,797		37,797		12
13	CNA Training	337	675		1,012		1,012	1,668	2,680		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,719,360	370,070	627,308	2,716,738	(404,672)	2,312,066	186,079	2,498,145		16
	C. General Administration										
17	Administrative	84,050			84,050		84,050	65,030	149,080		17
18	Directors Fees							5,376	5,376		18
19	Professional Services			308,628	308,628		308,628	(297,015)	11,613		19
20	Dues, Fees, Subscriptions & Promotions			93,163	93,163	(51,465)	41,698	(25,959)	15,739		20
21	Clerical & General Office Expenses	206,469	23,627	18,077	248,173		248,173	131,980	380,153		21
22	Employee Benefits & Payroll Taxes			372,206	372,206		372,206	30,667	402,873		22
23	Inservice Training & Education			1,396	1,396		1,396	603	1,999		23
24	Travel and Seminar			10,632	10,632		10,632	(8,633)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			69,529	69,529		69,529	1,804	71,333		26
27	Other (specify):*			23,500	23,500		23,500	(23,500)			27
28	TOTAL General Administration	290,519	23,627	897,131	1,211,277	(51,465)	1,159,812	(119,647)	1,040,165		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,467,986	676,960	1,675,117	4,820,063	(456,137)	4,363,926	84,219	4,448,145		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-Elgin #0038307 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			127,403	127,403		127,403	10,615	138,018			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			82,643	82,643		82,643	15,171	97,814			32
33	Real Estate Taxes			57,354	57,354		57,354		57,354			33
34	Rent-Facility & Grounds							5,716	5,716			34
35	Rent-Equipment & Vehicles			604	604		604	1,384	1,988			35
36	Other (specify):*											36
37	TOTAL Ownership			268,004	268,004		268,004	32,886	300,890			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers						404,672		404,672			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee						51,465		51,465			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers						456,137		456,137			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,467,986	676,960	1,943,121	5,088,067		5,088,067	117,105	5,205,172			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-Elgin

0038307

Report Period Beginning: 01/01/06

Ending: 12/31/06

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		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	(125)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,051)	20		17
18	Fines and Penalties				18
19	Entertainment	(17,500)	24		19
20	Contributions	(1,500)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,631)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,000)	27		24
25	Fund Raising, Advertising and Promotional	(30,018)	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		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (76,825)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	193,930		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 193,930		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 117,105		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Elgin

ID# 0038307

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(1,051)	20
18			18
19			24
20		(1,500)	27
21			21
22		(4,631)	19
23			23
24		(22,000)	27
25		(30,018)	20
26			26
27			27
28			28
29		0	33
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	(59,200)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Elgin# 0038307

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,767	0	0	0	0	0	0	0	0	4,767	1
2	Food Purchase	0	0	5	0	0	0	0	0	0	0	0	5	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,280	0	0	0	0	0	0	0	0	1,280	5
6	Maintenance	0	0	11,735	0	0	0	0	0	0	0	0	11,735	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	17,787	0	0	0	0	0	0	0	0	17,787	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,757	0	0	0	0	0	0	0	0	1,757	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	181,401	0	0	0	0	0	0	0	0	0	181,401	10a
11	Activities	0	0	1,253	0	0	0	0	0	0	0	0	1,253	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,668	0	0	0	0	0	0	0	0	1,668	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	181,401	4,678	0	0	0	0	0	0	0	0	186,079	16
	C. General Administration													
17	Administrative	0	0	65,030	0	0	0	0	0	0	0	0	65,030	17
18	Directors Fees	0	0	5,376	0	0	0	0	0	0	0	0	5,376	18
19	Professional Services	(4,631)	(303,997)	11,613	0	0	0	0	0	0	0	0	(297,015)	19
20	Fees, Subscriptions & Promotions	(31,069)	0	5,110	0	0	0	0	0	0	0	0	(25,959)	20
21	Clerical & General Office Expenses	0	0	131,980	0	0	0	0	0	0	0	0	131,980	21
22	Employee Benefits & Payroll Taxes	0	0	30,667	0	0	0	0	0	0	0	0	30,667	22
23	Inservice Training & Education	0	0	603	0	0	0	0	0	0	0	0	603	23
24	Travel and Seminar	(17,500)	0	8,867	0	0	0	0	0	0	0	0	(8,633)	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	1,804	0	0	0	0	0	0	0	0	1,804	26
27	Other (specify):*	(23,500)	0	0	0	0	0	0	0	0	0	0	(23,500)	27
28	TOTAL General Administration	(76,700)	(303,997)	261,050	0	0	0	0	0	0	0	0	(119,647)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(76,700)	(122,596)	283,515	0	0	0	0	0	0	0	0	84,219	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Elgin

0038307

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	10,615	0	0	0	0	0	0	0	10,615	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(125)	0	0	15,296	0	0	0	0	0	0	0	15,171	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	5,716	0	0	0	0	0	0	0	5,716	34
35	Rent-Equipment & Vehicles	0	0	0	1,384	0	0	0	0	0	0	0	1,384	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(125)	0	0	33,011	0	32,886	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(76,825)	(122,596)	283,515	33,011	0	117,105	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
See Attached						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization						2
3	V							3
4	V	19 Adjustment for Related Organization	303,997	Heritage Enterprises, Inc.			(303,997)	4
5	V							5
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		181,401	181,401	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 303,997			\$ 181,401	\$ * (122,596)	14

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

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/06 Ending: 12/31/06

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.	100.00%	\$ 4,767	\$ 4,767	15
16	V	2 Food Purchase				5	5	16
17	V	3 Housekeeping				0		17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,280	1,280	19
20	V	6 Maintenance				11,735	11,735	20
21	V	7 Other				0		21
22	V	9 Medical Director				1,757	1,757	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,253	1,253	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				1,668	1,668	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				65,030	65,030	29
30	V	18 Directors Fees				5,376	5,376	30
31	V	19 Professional Services				11,613	11,613	31
32	V	20 Fees, Subscription, Promotions				5,110	5,110	32
33	V	21 Clerical & General Office Expenses				131,980	131,980	33
34	V	22 Employee Benefits & Payroll Taxes				30,667	30,667	34
35	V	23 Inservice Training & Education				603	603	35
36	V	24 Travel and Seminar				8,867	8,867	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				1,804	1,804	38
39	Total		\$			\$ 283,515	\$ * 283,515	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.	100.00%	\$ 0	\$	15
16	V	30 Depreciation				10,615	10,615	16
17	V	31 Amortization of Pre-Op & Org				0		17
18	V	32 Interest				15,296	15,296	18
19	V	33 Real Estate Taxes				0		19
20	V	34 Rent-Facility & Grounds				5,716	5,716	20
21	V	35 Rent-Equipment & Vehicles				1,384	1,384	21
22	V	36 Other				0		22
23	V	38 Medically Nec Transportation				0		23
24	V	39 Ancillary Service Centers				0		24
25	V	40 Barber and Beauty Shops				0		25
26	V	41 Coffee and Gift Shops				0		26
27	V	42 Other				0		27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 33,011	\$ *	33,011 39

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

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Susie Jefferson	Director	Management	15.86		10	100.00	Brd Fees/salar	\$ 14,253	Line 17/18	1
2	Craig Hart	Chairman	Management	31.95		10	100.00	Brd Fees/salary	17,006	Line 17/18	2
3	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Brd Fees/salary	9,729	Line 17/18	3
4	Steve Wannemacher	President	Management	0.42		40	100.00	Brd Fees/salary	12,728	Line 17/18	4
5	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Brd Fees/salary	6,363	Line 17/18	5
6	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Brd Fees/salary	7,173	Line 17/18	6
7	Ben Hart	Vice President	Management	3.20		40	100.00	Brd Fees/salary	3,154	Line 17/18	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 70,406		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-Elgin

0038307

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	1	Dietary	Beds 2,624	25	\$ 133,074	\$ 132,833	94	\$ 4,767	1
2	2	Food Purchase	Beds 2,624	25	143	0	94	5	2
3	3	Housekeeping	Beds 2,624	25	0	0	94	0	3
4	4	Laundry	Beds 2,624	25	0	0	94	0	4
5	5	Heat & Other Utilities	Beds 2,624	25	35,724	0	94	1,280	5
6	6	Maintenance	Beds 2,624	25	327,581	62,300	94	11,735	6
7	7	Other	Beds 2,624	25	0	0	94	0	7
8	9	Medical Director	Beds 2,624	25	49,042	0	94	1,757	8
9	10	Nursing & Medical Records	Beds 2,624	25	0	49,042	94	0	9
10	11	Activities	Beds 2,624	25	34,967	0	94	1,253	10
11	12	Social Service	Beds 2,624	25	0	34,801	94	0	11
12	13	Nurse Aide Training	Beds 2,624	25	46,566	41,273	94	1,668	12
13	14	Program Transportation	Beds 2,624	25	0	0	94	0	13
14	15	Other	Beds 2,624	25	0	0	94	0	14
15	17	Administrative	Beds 2,624	25	1,815,310	1,815,310	94	65,030	15
16	18	Directors Fees	Beds 2,624	25	150,067	0	94	5,376	16
17	19	Professional Services	Beds 2,624	25	324,175	0	94	11,613	17
18	20	Fees, Subscription, Promotions	Beds 2,624	25	142,650	0	94	5,110	18
19	21	Clerical & General Office Expense	Beds 2,624	25	3,684,216	3,344,318	94	131,980	19
20	22	Employee Benefits & Payroll Tax	Beds 2,624	25	856,060	0	94	30,667	20
21	23	Inservice Training & Education	Beds 2,624	25	16,846	0	94	603	21
22	24	Travel and Seminar	Beds 2,624	25	247,517	0	94	8,867	22
23	25	Other Admin. Staff Transportatio	Beds 2,624	25	0	0	94	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds 2,624	25	50,353	0	94	1,804	24
25	TOTALS				\$ 7,914,291	\$ 5,479,877		\$ 283,515	25

Facility Name & ID Number Heritage Manor-Elgin

0038307

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,624	25	\$	94	\$	1
2	30	Depreciation	Beds	2,624	25	296,327	94	10,615	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		94		3
4	32	Interest	Beds	2,624	25	426,988	94	15,296	4
5	33	Real Estate Taxes	Beds	2,624	25		94		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	159,570	94	5,716	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	38,632	94	1,384	7
8	36	Other	Beds	2,624	25		94		8
9	38	Medically Nec Transportation	Beds	2,624	25		94		9
10	39	Ancillary Service Centers	Beds	2,624	25		94		10
11	40	Barber and Beauty Shops	Beds	2,624	25		94		11
12	41	Coffee and Gift Shops	Beds	2,624	25		94		12
13	42	Other	Beds	2,624	25		94		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					\$ 921,517	\$	\$ 33,011	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LsSalle National Bank		xx	Mortgage	13440 + Int	4/1/2006	\$	\$ 802,337	4/1/2011	variable	\$ 61,522	1								
2	LsSalle National Bank		xx	Mortgage							4,119	2								
3												3								
4												4								
5												5								
Working Capital																				
6	LsSalle National Bank		xx	Working Capital						variable	17,002	6								
7	LsSalle National Bank		xx									7								
8												8								
9	TOTAL Facility Related						\$	\$ 802,337			\$ 82,643	9								
B. Non-Facility Related*																				
10	Interest Income										(125)	10								
11	Allocated Corporate										15,296	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 15,171	14								
15	TOTALS (line 9+line14)						\$	\$ 802,337			\$ 97,814	15								

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.	\$	<u>52,907</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<u>53,786</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>879</u>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>56,475</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<u>57,354</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001	<u>42,327</u>	8
	2002	<u>42,058</u>	9
	2003	<u>43,635</u>	10
	2004	<u>49,307</u>	11
	2005	<u>53,167</u>	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Elgin COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0038307

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-24-201-002</u>	<u>Nursing Home</u>	\$ <u>1,301.00</u>	\$ <u>1,301.00</u>
2. <u>06-24-201-003</u>	<u></u>	\$ <u>51,499.00</u>	\$ <u>51,499.00</u>
3. <u>06-24-201-004</u>	<u></u>	\$ <u>986.00</u>	\$ <u>986.00</u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>53,786.00</u>	\$ <u>53,786.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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-Elgin

0038307 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,804 B. General Construction Type: Exterior Brick/Wood Frame Wood Number of Stories 1

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

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

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

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

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

none

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>80,000</u>	1
2					2
3	TOTALS			\$ <u>80,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	94				\$ 720,000	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	1989 Improvements			1989	180,739						9
10	1990 Improvements			1990	658,346						10
11	1990 Improvements			1990	4,320						11
12	1991 Improvements			1991	52,989						12
13	1992 Improvements			1992	6,777						13
14	1993 Improvements			1993	54,564						14
15	1994 Improvements			1994	81,347						15
16	1995 Improvements			1995	146,394						16
17	Remodel Resident Day Room/Nurses Station			1996	23,749						17
18	Interior Rehab			1997	751						18
19	Electric Water Heater			1997	3,965						19
20	Booster Heater			1997	1,622						20
21	Water Heater and Storage Tank			1998	6,485						21
22											22
23	Water Heater			1999	4,750						23
24	Code Alert System			1999	1,570						24
25	Resident Room Remodel--Material and Labor			1999	2,571						25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							10,615	10,615		34
35	Book Depreciation					84,908		84,908		1,027,850	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-Elgin

0038307

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	South Wing Remodel -- Labor / Materials	2000	\$ 14,334	\$		\$	\$	\$	37
38	Door	2000	1,535						38
39	Dry Chemical Extinguisher	2000	1,746						39
40									40
41	Water Heater	2001	4,935						41
42	Valve thermometer	2001	4,520						42
43	A/C Unit	2001	3,319						43
44	Hallway Carpet and Tile Material and Labor	2001	28,843						44
45	Wallpaper	2001	2,390						45
46	Nurse Call System	2001	21,612						46
47									47
48	Hallway and Room Carpet and Tile Material	2002	74,533						48
49	Labor	2002	68,734						49
50	Professional Fees	2002	16,497						50
51	Kitchen Pipe	2002	1,830						51
52	Shower Repairs	2002	5,063						52
53	A/C Unit	2002	5,864						53
54	Bathroom Rehab	2002	750						54
55	Condensor	2002	1,600						55
56	Hallway and Room Carpet and Tile Material --South wing	2002	5,777						56
57									57
58	Hallway and Room Carpet and Tile Material --South wing	2003	92,993						58
59	Exterior Door	2003	320						59
60	Parking Lot Sealer	2003	4,469						60
61	Door Security	2003	2,160						61
62	Ductwork	2003	6,628						62
63	compressor	2003	1,195						63
64	Blower Unit	2003	1,784						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,324,370	\$ 84,908		\$ 95,523	\$ 10,615	\$ 1,027,850	70

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

Facility Name & ID Number Heritage Manor-Elgin

0038307

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	Totals from Page 12A, Carried Forward		\$ 2,324,370	\$ 84,908		\$ 95,523	\$ 10,615	\$ 1,027,850	1
2									2
3	Exhaust fan	2005	1,950						3
4	Exterior Doors	2005	2,218						4
5	Compressor	2005	1,608						5
6									6
7	Fire Alarm	2006	1,714						7
8	Parking Lot	2006	2,344						8
9	Remodel Corridor --paint	2006	4,028						9
10	Water Main	2006	3,250						10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,341,482	\$ 84,908		\$ 95,523	\$ 10,615	\$ 1,027,850	34

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

Facility Name & ID Number Heritage Manor-Elgin

0038307

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		\$ 2,341,482	\$ 84,908		\$ 95,523	\$ 10,615	\$ 1,027,850	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,341,482	\$ 84,908		\$ 95,523	\$ 10,615	\$ 1,027,850	34

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

Facility Name & ID Number Heritage Manor-Elgin # 0038307 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 607,820	\$ 42,495	\$ 42,495	\$		\$ 505,109	71
72	Current Year Purchases	24,200						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 632,020	\$ 42,495	\$ 42,495	\$		\$ 505,109	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,053,502	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 127,403	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 138,018	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,615	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,532,959	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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 1,988 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <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		675		675
3	Classroom Wages (a)		337		337
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,012	\$	\$ 1,012
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,012		

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.

Facility Name & ID Number Heritage Manor-Elgin# 0038307

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$		\$ 282,779	\$		\$ 282,779	1
2	Licensed Speech and Language Development Therapist		hrs			64,402			64,402	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			257,848	1,339		259,187	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				400,121		400,121	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					4,551			4,551	13
14	TOTAL			\$		\$ 609,580	\$ 401,460		\$ 1,011,040	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-Elgin# 0038307Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 10,454	\$	1
2	Cash-Patient Deposits	36,099		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,002,909		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,904		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,447,762)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (377,396)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	80,000		13
14	Buildings, at Historical Cost	2,341,482		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	632,020		16
17	Accumulated Depreciation (book methods)	(1,532,959)		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): <u>Loan Fees</u>	21,302		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,541,845	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,164,449	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 139,604	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,099		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	212,391		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,107		31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,475		32
33	Accrued Interest Payable	11,105		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)	\$ 485,781	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	802,337		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deposits</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 802,337	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,288,118	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (123,669)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,164,449	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,258,630	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,258,630	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(57,299)	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	(1,325,000)	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)	\$ (1,382,299)	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)	\$ (123,669)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Elgin# 0038307Report Period Beginning: 01/01/06Ending: 12/31/06**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	\$ 4,637,684	1
2	Discounts and Allowances for all Levels	(1,876,514)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,761,170	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,883,802	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,883,802	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	114	12
13	Barber and Beauty Care	1,284	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	382,722	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,551	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 385,671	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	125	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 125	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)	\$ 5,030,768	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	892,048	31
32	Health Care	2,716,738	32
33	General Administration	1,211,277	33
B. Capital Expense			
34	Ownership	268,004	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	<u>Non Nursing Home Expenses</u>		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,088,067	40
41	Income before Income Taxes (line 30 minus line 40)**	(57,299)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (57,299)	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-Elgin

0038307

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	1,960	2,080	\$ 64,986	\$ 31.24	1
2	Assistant Director of Nursing	1,970	2,106	59,048	28.04	2
3	Registered Nurses	14,724	15,628	477,554	30.56	3
4	Licensed Practical Nurses	7,977	8,415	187,047	22.23	4
5	CNAs & Orderlies	51,939	55,325	752,811	13.61	5
6	CNA Trainees	40	40	337	8.43	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,040	4,367	65,044	14.89	8
9	Activity Director					9
10	Activity Assistants	6,175	6,370	77,622	12.19	10
11	Social Service Workers	2,152	2,504	34,911	13.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,107	13,288	223,205	16.80	15
16	Dishwashers					16
17	Maintenance Workers	6,446	6,737	96,981	14.40	17
18	Housekeepers	9,851	11,070	98,007	8.85	18
19	Laundry	3,832	4,626	39,914	8.63	19
20	Administrator	1,950	2,080	84,050	40.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,112	13,832	206,469	14.93	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)	136,275	148,468	\$ 2,467,986 *	\$ 16.62	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		894		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,820		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		2,886		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,600		49

C. CONTRACT NURSES

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

XX. GENERAL INFORMATION:

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

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 51,465
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. \$ 0
- (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? _____
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? _____
g. Does the facility transport residents to and from day training? _____
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Not available at this time
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

Name	Title	Function	Ownership Interest	Compensation Received From Other Homes	Week Devoted to this Business and % of Total Work Week	Description	Compensation in Costs for Reporting	Schedule V Line & Column	Total Pay	Amount Paid by Mgmt	Total # Beds	Facility # Beds	Non-Nursing Home	Nursing Home	This Facility
#REF!	Susie Jeffe	Director	0	383,600	10	0 Salary	14,253	ine 17, col 1	#REF!	417,825	417,825	19,972	397,853	14,252	
#REF!	Craig Hart	Chairman	0	457,703	10	0 Salary	17,006	ine 17, col 1	#REF!	498,540	498,540	23,831	474,709	17,006	
#REF!	Cheryl Lov	Executive	0	261,865	50	1 Salary	9,729	ine 17, col 1	#REF!	285,228	285,228	13,634	271,594	9,729	
#REF!	Steve War	President	0	342,575	50	1 Salary	12,728	ine 17, col 1	#REF!	373,139	373,139	17,836	355,303	12,728	
#REF!	Connie Ho	Sr Vice Pres	0	171,263	40	1 Salary	6,363	ine 17, col 1	#REF!	186,543	186,543	8,917	177,626	6,363	
#REF!	Craig Ater	Sr Vice Pres	0	193,063	50	1 Salary	7,173	ine 17, col 1	#REF!	210,288	210,288	10,052	200,236	7,173	
	Ben Hart	Vice Pres		84,902			3,154			92,476	92,476	4,420	88,056	3,154	
13				1,894,971		TOTAL	70,406		13	2,064,039	2,064,039		1,965,377	70,405	

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the homes(s) as well as the amount paid. This amount must agree to the amounts disclosed.

#REF! 0 ##### total salaries
67,252 #####

**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.

0 total mgt fees

