

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0018176

Facility Name: Heritage Square

Address: 620 North Ottawa Avenue Dixon 61021
 Number City Zip Code

County: Lee

Telephone Number: (815)288-2251 **Fax #** (815)288-6821

HFS ID Number: 36-605435-7001

Date of Initial License for Current Owners: 11/08/74

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501© (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: Norman J. Gross, Admn. **Telephone Number:** (815)288-2251
J. O'Farrell, Bookkeeper

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Norman J. Gross</u>	
	(Title) <u>Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>N/A</u>	
	(Firm Name & Address) _____	
	(Telephone) <u>()</u> Fax # <u>()</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Heritage Square

0018176 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 03/17/04

	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>25</u>	Skilled (SNF)	<u>25</u>	<u>9,125</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>49</u>	Sheltered Care (SC)	<u>49</u>	<u>17,885</u>	5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>74</u>	<u>27,010</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF	<u>1,875</u>	<u>7,665</u>		<u>9,540</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>14,600</u>		<u>14,600</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,875</u>	<u>22,265</u>		<u>24,140</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.37%

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)

0

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 11/07/1974

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 _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 1/1/2006 Ending: 12/31/2006

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	212,928	17,449	1,828	232,205		232,205		232,205		1
2	Food Purchase		174,732		174,732		174,732	(10,223)	164,509		2
3	Housekeeping	91,156	14,327	2,693	108,176		108,176		108,176		3
4	Laundry	22,430	4,395		26,825		26,825		26,825		4
5	Heat and Other Utilities			80,327	80,327		80,327		80,327		5
6	Maintenance	79,739	33,553	11,886	125,178		125,178		125,178		6
7	Other (specify):* Waste Removal			3,783	3,783		3,783		3,783		7
8	TOTAL General Services	406,253	244,456	100,517	751,226		751,226	(10,223)	741,003		8
	B. Health Care and Programs										
9	Medical Director			1,800	1,800		1,800		1,800		9
10	Nursing and Medical Records	783,156	25,326	1,050	809,532		809,532		809,532		10
10a	Therapy	11,221		1,881	13,102		13,102		13,102		10a
11	Activities	77,051	3,304	3,652	84,007		84,007		84,007		11
12	Social Services	40,553	543	939	42,035		42,035		42,035		12
13	CNA Training										13
14	Program Transportation		1,404	4,355	5,759		5,759		5,759		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	911,981	30,577	13,677	956,235		956,235		956,235		16
	C. General Administration										
17	Administrative	76,110			76,110		76,110		76,110		17
18	Directors Fees										18
19	Professional Services			11,341	11,341		11,341		11,341		19
20	Dues, Fees, Subscriptions & Promotions			40,465	40,465		40,465	(31,459)	9,006		20
21	Clerical & General Office Expenses	95,088	11,786	23,595	130,469		130,469	(21,068)	109,401		21
22	Employee Benefits & Payroll Taxes			313,657	313,657		313,657		313,657		22
23	Inservice Training & Education			943	943		943		943		23
24	Travel and Seminar			1,959	1,959		1,959		1,959		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			75,609	75,609		75,609		75,609		26
27	Other (specify):*										27
28	TOTAL General Administration	171,198	11,786	467,569	650,553		650,553	(52,527)	598,026		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,489,432	286,819	581,763	2,358,014		2,358,014	(62,750)	2,295,264		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 Square #0018176 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			118,154	118,154	118,154		118,154				30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(385,299)	(385,299)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			118,154	118,154	118,154		(385,299)	(267,145)			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			13,688	13,688	13,688		13,688	13,688			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			13,688	13,688	13,688			13,688			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,489,432	286,819	713,605	2,489,856	2,489,856		(448,049)	2,041,807			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 Square

0018176

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	10,233	-A-2-7		4
5	Telephone, TV & Radio in Resident Rooms	15,884	-C-21-7		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	385,299	-D-32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	779	-C-21-7		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	1,166	-C-21-7		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	31,459	-C-20-7		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	3,239	-C-21-7		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 448,059		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 448,059		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 Square

ID# 0018176

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Square

0018176

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,965)	0	0	0	0	0	0	0	0	0	0	(10,965)	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,965)	0	0	0	0	0	0	0	0	0	0	(10,965)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(31,459)	0	0	0	0	0	0	0	0	0	0	(31,459)	20
21	Clerical & General Office Expenses	(19,902)	0	0	0	0	0	0	0	0	0	0	(19,902)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(51,361)	0	0	0	0	0	0	0	0	0	0	(51,361)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(62,326)	0	0	0	0	0	0	0	0	0	0	(62,326)	29

STATE OF ILLINOIS

Facility Name & ID Number Heritage Square

0018176 Report Period Beginning:

01/01/06 Ending:

Summary B

12/31/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	118,154	0	0	0	0	0	0	0	0	0	0	118,154	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(385,299)	0	0	0	0	0	0	0	0	0	0	(385,299)	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	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(267,145)	0	(267,145)	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	13,688	0	0	0	0	0	0	0	0	0	0	13,688	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	13,688	0	13,688	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(315,783)	0	(315,783)	45									

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

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							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Heritage Square # 0018176 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									\$		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 Square

0018176 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
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	TOTALS				\$	\$		\$	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										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$	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

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2001	_____	8		
2002	_____	9		
2003	_____	10		
2004	_____	11		
2005	_____	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 Square COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0018176

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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 Square

0018176 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,354 B. General Construction Type: Exterior Brick Frame Steel Griders,Metal La Number of Stories 2

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).

1. Warner Campus - 2 Free Standing Buildings which equals 4 units

2. Each of the above 4 units equal 1160 sq. ft. each, plus garage.

(Above information taken from architect prints.)

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>Home for Aged</u>	<u>97,046</u>	<u>1963</u>	<u>\$ 42,888</u>	<u>1</u>
2				<u>31,315</u>	<u>2</u>
3	TOTALS	97,046		\$ 74,203	3

Facility Name & ID Number Heritage Square

0018176

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1974	1974	\$ 1,532,081	\$ 38,302	40	\$ 38,302		\$ 1,235,337	4
5	74		1993	1993	1,100,199	27,505	40	27,505		371,317	5
6											6
7											7
8											8
	Improvement Type**										
9		Outdoor Lights		1977	696		20			696	9
10		Patio Cover		1980	3,729		10			3,729	10
11		Storeroom Sprinkler		1981	1,309		20			1,309	11
12		P.T. & Rehab. Rm.		1985	18,461		18			18,461	12
13		L.L. Act. (Resigned B.SP.)		1985	3,229		19			3,229	13
14		Soc.Service Office		1988	1,319	62	20	62		1,236	14
15		Roof (HCC Wing)		1988	5,940		15			5,940	15
16		Asphalt Driveway		1989	2,571		15			2,571	16
17		Ceiling (HCC)		1989	1,557		15			1,557	17
18		Parking Lot		1989	11,398	541	20	541		9,831	18
19		Gutter & downspouts (S.Wing)		1991	4,500	230	15	230		4,500	19
20		Vinyl Floor Coverings (Sheltered Care)		1991	487		10			487	20
21		Plumbing Replacement		1991	2,099	100	20	100		1,601	21
22		Storage Shed		1991	1,189	57	20	57		905	22
23		Fire Alarm Improvments		1991	1,630	77	20	77		1,245	23
24		Intercom Improvements		1992	508	32	15	32		480	24
25		Fire Protection Beams		1993	1,380		10			1,380	25
26		Wall Papering		1993	2,927		5			2,927	26
27		Concrete Walk & Driveway		1993	6,008	374	15	374		5,376	27
28		Landscaping (New Wing)		1993	7,749		10			7,749	28
29		Resurface Parking Lot		1993	17,716	1,103	15	1,103		15,512	29
30		Gutters & Downspouts (N. Wind)		1993	3,600	224	15	224		3,160	30
31		Heating (HCC Floor)		1994	3,966		10			3,966	31
32		Elevator Safety Shield		1994	1,250		10			1,250	32
33		Concrete Walk & Bench Pad		1994	1,225	58	20	58		780	33
34		Painting Facia of Building		1994	1,955		5			1,955	34
35		Life Safety Door Closer (replace)		1995	4,432	276	15	276		3,293	35
36		(Cont'd on page 12-A)									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 Square

0018176

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	Patio Sidewalk (Replace)	1995	\$ 6,507	\$ 310	20	\$ 310	\$	\$ 3,659	37
38	Paint Soffits & Frames	1995	2,975		5			2,975	38
39	Soffit Repair (Vinyl)	1995	4,100	195	20	195		2,307	39
40	Nurse Office Floor & Walls (First Floor)	1996	761		5			761	40
41	Paint & Paper (HCC,SC,BSM)	1996	4,887		5			4,887	41
42	Attic Ventilation (S.Wing in S.C.)	1996	11,600	551	20	551		5,945	42
43	Exterior Walks & Drive	1996	3,809	181	20	181		1,951	43
44	N.E. Outdoor Storage shed	1996	707	34	20	34		361	44
45	Lighting Replacement (Energy Efficient)	1997	13,031	811	15	811		7,964	45
46	Radiant Heat Panels (S.C.)	1998	19,894	1,791	10	1,791		16,079	46
47	Bed Bumper Guards (HCC)	1998	765		5			765	47
48	Kitchen Fire System	1998	898	42	20	42		352	48
49	8 Attice Exhaust Fans (S.C.)	1998	6,356	302	20	302		2,570	49
50	Painting	1999	11,227		5			11,227	50
51	Deposit Bldg. Extens.	2000	2,346						51
52	GFI Electrical Upgrades	2000	4,800	228	20	228		1,400	52
53	Paint Halls & Doors	2001	5,970	955	5	955		5,871	53
54	New South Roof	2002	171,935	5,731	30	5,731		24,357	54
55	New Roof	2003	140,137	4,671	30	4,671		14,792	55
56	Replacement of Clay Tile & Pvc	2005	1,153	39	30	39		61	56
57	Repaid & Replace No. Driveway	2005	9,330	622	15	622		674	57
58	Bathrrom Tile	2005	1,500	75	20	75		138	58
59	Repair & Waterproof Balcony	2005	6,500	325	20	325		460	59
60	Exit/Cylinder Change Room Doors	2005	4,426	222	20	222		314	60
61	Prime & Paint Handrail on Bldg.	2005	3,360	336	10	336		420	61
62	New Locks on half the Resident doors	2006	2,897	84	20	84		84	62
63	Carpet for Offices & entrance	2006	7,307	853	5	853		853	63
64	Concrete Work	2006	2,595	58	15	58		58	64
65	Automatic Door for Courtyard	2006	2,665	22	20	22		22	65
66	Asphalt half circle driveway	2006	2,300	38	15	38		38	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,201,848	\$ 87,417		\$ 87,417	\$	\$ 1,823,124	70

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

Facility Name & ID Number Heritage Square # 0018176 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	\$ 528,264	\$ 25,724	\$ 25,724	\$		\$ 379,429	71
72	Current Year Purchases	42,518	1,760	1,760			1,760	72
73	Fully Depreciated Assets							73
74	Less Dispostions	(15,357)					(16,165)	74
75	TOTALS	\$ 555,425	\$ 27,484	\$ 27,484	\$		\$ 365,024	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	Patient Transport	2001 Grand Marquis Mercury	2005	\$ 13,011	\$ 3,253	\$ 3,253	\$	4	\$ 3,524	76
77										77
78										78
79										79
80	TOTALS			\$ 13,011	\$ 3,253	\$ 3,253	\$		\$ 3,524	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)	\$ 3,844,487	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 118,154	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 118,154	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,191,672	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: \$ _____ 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 checked="" 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><u>We Hire Certified Nurses Aides</u></p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 Square# 0018176Report 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	\$ 2,821,388	\$	1
2	Cash-Patient Deposits	28,014		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,294		3
4	Supply Inventory (priced at <u>Cost</u>)	21,234		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	17,943		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Pledges Receivable</u>	76,461		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,971,334	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable	138,470		11
12	Long-Term Investments	931,885		12
13	Land	74,203		13
14	Buildings, at Historical Cost	3,185,684		14
15	Leasehold Improvements, at Historical Cost	568,434		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(2,214,786)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	585,275		21
22	Other Long-Term Assets (spe <u>Int.Pepetual Trust</u>)	5,140,784		22
23	Other(specify): <u>R.L.Warner Campus</u>	188,305		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,598,254	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,569,588	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 41,298	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	119,944		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,176		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 170,418	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Gift Annuity</u>	1,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 171,418	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,398,170	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,569,588	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,052,887	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,052,887	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	345,283	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 345,283	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)	\$ 11,398,170	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Square# 0018176Report 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	\$ 2,313,320	1
2	Discounts and Allowances for all Levels	(163,460)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,149,860	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,162	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 15,162	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	361	12
13	Barber and Beauty Care	1,583	13
14	Non-Patient Meals	10,223	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	13,724	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 25,891	23
D. Non-Operating Revenue			
24	Contributions	30,522	24
25	Interest and Other Investment Income***	385,299	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 415,821	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Beneficial Trust	132,550	28
28a	Gain or Loss on Assets/Stock	87,644	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 220,194	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,826,928	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	743,015	31
32	Health Care	956,235	32
33	General Administration	650,553	33
B. Capital Expense			
34	Ownership	118,154	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	13,688	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,481,645	40
41	Income before Income Taxes (line 30 minus line 40)**	345,283	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 345,283	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

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0018176

Report Period Beginning:

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,931	2,080	\$ 56,995	\$ 27.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,198	6,676	134,707	20.18	3
4	Licensed Practical Nurses	14,641	15,527	272,747	17.57	4
5	CNAs & Orderlies	29,970	33,130	318,706	9.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	996	1,155	11,221	9.72	8
9	Activity Director	2,341	2,640	42,906	16.25	9
10	Activity Assistants	4,897	5,192	37,857	7.29	10
11	Social Service Workers	3,028	3,246	40,186	12.38	11
12	Dietician					12
13	Food Service Supervisor	1,933	2,080	33,387	16.05	13
14	Head Cook	3,238	3,393	31,119	9.17	14
15	Cook Helpers/Assistants	16,122	16,482	125,897	7.64	15
16	Dishwashers	3,053	3,194	22,445	7.03	16
17	Maintenance Workers	2,914	3,130	79,740	25.48	17
18	Housekeepers	7,600	8,191	91,155	11.13	18
19	Laundry	2,813	3,026	22,430	7.41	19
20	Administrator	1,872	2,080	76,110	36.59	20
21	Assistant Administrator					21
22	Other Administrative	1,999	2,120	43,768	20.65	22
23	Office Manager	1,878	2,080	31,139	14.97	23
24	Clerical	1,827	2,506	20,181	8.05	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)	109,251	117,928	\$ 1,492,696 *	\$ 12.66	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	Contract	\$ 1,813	V-A-1-3	35
36	Medical Director	Contract	1,800	V-B-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	25	925	V-B-10-3	39
40	Physical Therapy Consultant	Contract	1,843	V-B-10a-3	40
41	Occupational Therapy Consultant	2	38	V-B-10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	1,282	V-B-11-3	44
45	Social Service Consultant	11	939	V-B-12-3	45
46	Other(specify) <u>Chaplain</u>	Contract	1,905	V-B-11-3	46
47	<u>QA Physicians</u>	6	125	V-B-10-3	47
48	<u>Sunday Clergy</u>	31	465	V-B-11-3	48
49	TOTAL (lines 35 - 48)	95	\$ 11,135		49

C. CONTRACT NURSES

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

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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	
Norman J. Gross	Administrator	0	\$ 76,110	Workers' Compensation Insurance	\$ 39,201	IDPH License Fee	\$ 100	
				Unemployment Compensation Insurance	0	Advertising: Employee Recruitment	574	
				FICA Taxes	113,219	Health Care Worker Background Check		
				Employee Health Insurance	153,034	(Indicate # of checks performed <u>27</u>)	432	
				Employee Meals		Patient Background Checks <u>63</u>	1,008	
				Illinois Municipal Retirement Fund (IMRF)*		LSN/AAHSA	6,562	
				Employee Physicals	4,213	Assoc.Dues INHAA	200	
						IL Activity Prof.Dues	130	
							0	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 76,110	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 309,667		\$ 9,006		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	638
							Seminar Expense	1,321
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	Entertainment Expense	()
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
C. Professional Services							TOTAL	
Vendor/Payee	Type	Amount					\$ 1,959	
Clifton & Gunderson	Audit	\$ 9,000						
Clifton & Gunderson	Data Process	1,490						
Ehman,Gehlbach,Badger,Lee	Attorney	851						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 11,341					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	Repair Ice Machine	2/07/06	\$ 116		\$	\$	\$	\$	\$ 116	\$	\$	\$	\$
2	Carpentry Misc.	3/1/06	212						212				
3	Repair Fire Exting.	3/3/06	94						94				
4	Plumbing	3/7/06	337						337				
5	Plumbing	3/15/06	464						464				
6	Plumbing	5/19/06	309						309				
7	Repair Fire Exting.	6/23/06	288						288				
8	Carpentry Misc.	7/11/06	600						600				
9	Carpentry Misc.	10/02/06	14						14				
10	Carpentry Misc.	12/05/06	1,150						1,150				
11	Carpentry Misc.	12/06/06	92						92				
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,675		\$	\$	\$	\$	\$ 3,676	\$	\$	\$	\$

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. Life Servies Network \$6562.
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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? 15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,941 Line B-10-2
- (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 X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X 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. \$ 13,688
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,223
- (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? 90%
- 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? N/A
- 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Clifton Gunderson LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.