

		FOR BHF USE					

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License ID Number: 0048835

Facility Name: Heritage Manor-Beardstown East

Address: 1501 Canal Street Beardstown 62618
 Number City Zip Code

County: Cass

Telephone Number: (217) 323-1900 Fax # ()

HFS ID Number: 205300208001

Date of Initial License for Current Owners: 07/2007

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 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) _____	<u>04/15/08</u>
	(Type or Print Name) <u>Craig Ater</u>	(Date)
Paid Preparer	(Title) <u>Sr. VP & CFO</u>	
	(Signed) _____	(Date)
Paid Preparer	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____
	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 Manor-Beardstown East

0048835 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	71	Skilled (SNF)	71	25,915	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	71	TOTALS	71	25,915	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	13,645	4,579	1,541	19,765	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,645	4,579	1,541	19,765	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.27%

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)

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 07/2007

J. Was the facility purchased or leased after January 1, 1978?
YES Date 07/2007 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 1,541

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Manor-Beardstown East # 0048835 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	128,889	10,774		139,663		139,663	3,851	143,514		1
2	Food Purchase		119,830		119,830		119,830	16	119,846		2
3	Housekeeping	75,388	9,344		84,732		84,732		84,732		3
4	Laundry	20,887	8,789		29,676		29,676		29,676		4
5	Heat and Other Utilities			65,649	65,649		65,649	1,098	66,747		5
6	Maintenance	24,676	33,250	23,656	81,582		81,582	8,705	90,287		6
7	Other (specify):*										7
8	TOTAL General Services	249,840	181,987	89,305	521,132		521,132	13,670	534,802		8
	B. Health Care and Programs										
9	Medical Director			2,250	2,250		2,250	1,379	3,629		9
10	Nursing and Medical Records	824,505	56,383	4,799	885,687		885,687		885,687		10
10a	Therapy		126,018	110,327	236,345	(134,899)	101,446	175,140	276,586		10a
11	Activities	35,179	1,329		36,508		36,508	1,002	37,510		11
12	Social Services	12,473		2,475	14,948		14,948		14,948		12
13	CNA Training							1,276	1,276		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	872,157	183,730	119,851	1,175,738	(134,899)	1,040,839	178,797	1,219,636		16
	C. General Administration										
17	Administrative	62,413			62,413		62,413	45,682	108,095		17
18	Directors Fees							4,065	4,065		18
19	Professional Services			112,016	112,016		112,016	(106,303)	5,713		19
20	Dues, Fees, Subscriptions & Promotions			63,077	63,077	(38,873)	24,204	(5,059)	19,145		20
21	Clerical & General Office Expenses	64,018	14,236	14,410	92,664		92,664	100,288	192,952		21
22	Employee Benefits & Payroll Taxes			273,508	273,508		273,508	27,465	300,973		22
23	Inservice Training & Education			1,682	1,682		1,682	284	1,966		23
24	Travel and Seminar			3,017	3,017		3,017	(1,018)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			49,171	49,171		49,171	4,049	53,220		26
27	Other (specify):*			7,875	7,875		7,875	(7,875)			27
28	TOTAL General Administration	126,431	14,236	524,756	665,423	(38,873)	626,550	61,578	688,128		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,248,428	379,953	733,912	2,362,293	(173,772)	2,188,521	254,045	2,442,566		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-Beardstown East #0048835 Report Period Beginning: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			90,772	90,772		90,772	7,027	97,799			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			69,636	69,636		69,636	3,838	73,474			32
33	Real Estate Taxes			31,252	31,252		31,252		31,252			33
34	Rent-Facility & Grounds							4,291	4,291			34
35	Rent-Equipment & Vehicles			1,267	1,267		1,267	1,168	2,435			35
36	Other (specify):*											36
37	TOTAL Ownership			192,927	192,927		192,927	16,324	209,251			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers						134,899		134,899			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee						38,873		38,873			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers						173,772		173,772			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,248,428	379,953	926,839	2,555,220		2,555,220	270,369	2,825,589			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-Beardstown East

0048835

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	BHF 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	(910)	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	(716)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,620)	24		19
20	Contributions	(1,875)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,288)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	27		24
25	Fund Raising, Advertising and Promotional	(8,669)	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)	\$ (27,078)		\$	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)	297,447		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 297,447		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 270,369		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-Beardstown East

ID# 0048835

Report Period Beginning: 01/01/07

Ending: 12/31/07

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		(716)	20
18			18
19			24
20		(1,875)	27
21			21
22		(1,288)	19
23			23
24		(6,000)	27
25		(8,669)	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	(18,548)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Beardstown East

0048835

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	3,851	0	0	0	0	0	0	0	0	3,851	1
2	Food Purchase	0	0	16	0	0	0	0	0	0	0	0	16	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	1,098	0	0	0	0	0	0	0	0	1,098	5
6	Maintenance	0	0	8,705	0	0	0	0	0	0	0	0	8,705	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	13,670	0	0	0	0	0	0	0	0	13,670	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,379	0	0	0	0	0	0	0	0	1,379	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	175,140	0	0	0	0	0	0	0	0	0	175,140	10a
11	Activities	0	0	1,002	0	0	0	0	0	0	0	0	1,002	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,276	0	0	0	0	0	0	0	0	1,276	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	175,140	3,657	0	0	0	0	0	0	0	0	178,797	16
	C. General Administration													
17	Administrative	0	0	45,682	0	0	0	0	0	0	0	0	45,682	17
18	Directors Fees	0	0	4,065	0	0	0	0	0	0	0	0	4,065	18
19	Professional Services	(1,288)	(110,728)	5,713	0	0	0	0	0	0	0	0	(106,303)	19
20	Fees, Subscriptions & Promotions	(9,385)	0	4,326	0	0	0	0	0	0	0	0	(5,059)	20
21	Clerical & General Office Expenses	0	0	100,288	0	0	0	0	0	0	0	0	100,288	21
22	Employee Benefits & Payroll Taxes	0	0	27,465	0	0	0	0	0	0	0	0	27,465	22
23	Inservice Training & Education	0	0	284	0	0	0	0	0	0	0	0	284	23
24	Travel and Seminar	(7,620)	0	6,602	0	0	0	0	0	0	0	0	(1,018)	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	4,049	0	0	0	0	0	0	0	0	4,049	26
27	Other (specify):*	(7,875)	0	0	0	0	0	0	0	0	0	0	(7,875)	27
28	TOTAL General Administration	(26,168)	(110,728)	198,474	0	0	0	0	0	0	0	0	61,578	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,168)	64,412	215,801	0	0	0	0	0	0	0	0	254,045	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Beardstown East# 0048835

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	7,027	0	0	0	0	0	0	0	7,027	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(910)	0	0	4,748	0	0	0	0	0	0	0	3,838	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	4,291	0	0	0	0	0	0	0	4,291	34
35	Rent-Equipment & Vehicles	0	0	0	1,168	0	0	0	0	0	0	0	1,168	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(910)	0	0	17,234	0	16,324	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)	(27,078)	64,412	215,801	17,234	0	270,369	45						

Facility Name & ID Number Heritage Manor-Beardstown East

0048835

Report Period Beginning:

01/01/07

Ending:

12/31/07

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V	10a Adjustment for Related Organization					
3	V						
4	V	19 Adjustment for Related Organization	110,728	Heritage Enterprises, Inc.			(110,728)
5	V						
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		175,140	175,140
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 110,728			\$ 175,140	\$ * 64,412

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

Facility Name & ID Number Heritage Manor-Beardstown East# 0048835Report Period Beginning: 01/01/07Ending: 12/31/07

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%	\$	3,851	15
16	V	2 Food Purchase					16	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,098	19
20	V	6 Maintenance					8,705	20
21	V	7 Other					0	21
22	V	9 Medical Director					1,379	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					1,002	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,276	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					45,682	29
30	V	18 Directors Fees					4,065	30
31	V	19 Professional Services					5,713	31
32	V	20 Fees, Subscription, Promotions					4,326	32
33	V	21 Clerical & General Office Expenses					100,288	33
34	V	22 Employee Benefits & Payroll Taxes					27,465	34
35	V	23 Inservice Training & Education					284	35
36	V	24 Travel and Seminar					6,602	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					4,049	38
39	Total		\$			\$	0	\$ * 215,801 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		\$					100.00%	\$			0	15
16	V	30	Depreciation											7,027	16
17	V	31	Amortization of Pre-Op & Org												17
18	V	32	Interest											4,748	18
19	V	33	Real Estate Taxes											0	19
20	V	34	Rent-Facility & Grounds											4,291	20
21	V	35	Rent-Equipment & Vehicles											1,168	21
22	V	36	Other											0	22
23	V	38	Medically Nec Transportation											0	23
24	V	39	Ancillary Service Centers											0	24
25	V	40	Barber and Beauty Shops											0	25
26	V	41	Coffee and Gift Shops											0	26
27	V	42	Other											0	27
28	V														28
29	V														29
30	V														30
31	V														31
32	V														32
33	V														33
34	V														34
35	V														35
36	V														36
37	V														37
38	V														38
39	Total				\$						\$	0	\$ *	17,234	39

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

Facility Name & ID Number Heritage Manor-Beardstown East # 0048835 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					\$ 4,065	line 18	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	\$ 4,065		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-Beardstown East

0048835

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,624	25	\$ 142,342	\$ 142,057	71	\$ 3,851	1
2	2	Food Purchase	Beds	2,624	25	577	0	71	16	2
3	3	Housekeeping	Beds	2,624	25	0	0	71	0	3
4	4	Laundry	Beds	2,624	25	0	0	71	0	4
5	5	Heat & Other Utilities	Beds	2,624	25	40,565	0	71	1,098	5
6	6	Maintenance	Beds	2,624	25	321,709	65,509	71	8,705	6
7	7	Other	Beds	2,624	25	0	0	71	0	7
8	9	Medical Director	Beds	2,624	25	50,960	0	71	1,379	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	56,488	71	0	9
10	11	Activities	Beds	2,624	25	37,038	36,931	71	1,002	10
11	12	Social Service	Beds	2,624	25	0	0	71	0	11
12	13	Nurse Aide Training	Beds	2,624	25	47,168	47,168	71	1,276	12
13	14	Program Transportation	Beds	2,624	25	0	0	71	0	13
14	15	Other	Beds	2,624	25	0	0	71	0	14
15	17	Administrative	Beds	2,624	25	1,688,288	1,688,288	71	45,682	15
16	18	Directors Fees	Beds	2,624	25	150,218	0	71	4,065	16
17	19	Professional Services	Beds	2,624	25	211,148	0	71	5,713	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	159,872	0	71	4,326	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,706,408	3,356,042	71	100,288	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	1,015,049	0	71	27,465	20
21	23	Inservice Training & Education	Beds	2,624	25	10,511	0	71	284	21
22	24	Travel and Seminar	Beds	2,624	25	243,988	0	71	6,602	22
23	25	Other Admin. Staff Transportatio	Beds	2,624	25	0	0	71	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,624	25	149,629	0	71	4,049	24
25	TOTALS					\$ 7,975,470	\$ 5,392,483		\$ 215,801	25

Facility Name & ID Number Heritage Manor-Beardstown East

0048835

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$	71	\$	1
2	30	Depreciation	Beds	2,624	25	259,703	71	7,027	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		71		3
4	32	Interest	Beds	2,624	25	175,477	71	4,748	4
5	33	Real Estate Taxes	Beds	2,624	25		71		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587	71	4,291	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166	71	1,168	7
8	36	Other	Beds	2,624	25		71		8
9	38	Medically Nec Transportation	Beds	2,624	25		71		9
10	39	Ancillary Service Centers	Beds	2,624	25		71		10
11	40	Barber and Beauty Shops	Beds	2,624	25		71		11
12	41	Coffee and Gift Shops	Beds	2,624	25		71		12
13	42	Other	Beds	2,624	25		71		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					\$ 636,933	\$	\$ 17,234	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	J.P. Morgan		xx	Mortgage			\$	\$ 924,348		\$ 58,558	1									
2	J.P. Morgan		xx	Mortgage						1,285	2									
3											3									
4											4									
5											5									
Working Capital																				
6	LsSalle National Bank		xx	Working Capital						9,793	6									
7	LsSalle National Bank		xx								7									
8											8									
9	TOTAL Facility Related						\$	\$ 924,348		\$ 69,636	9									
B. Non-Facility Related*																				
10	Interest Income									(910)	10									
11	Allocated Corporate									4,748	11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ 3,838	14									
15	TOTALS (line 9+line14)						\$	\$ 924,348		\$ 73,474	15									

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 28,846	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.)		\$ 29,316	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 470	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 30,782	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.		\$ 31,252	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	22,281	8
	2003	22,916	9
	2004	23,197	10
	2005	27,608	11
	2006	31,252	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Beardstown East COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0048835

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 2006 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 2006.

(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>03-264-007-00</u>	<u>nursing home</u>	\$ <u>29,316.00</u>	\$ <u>29,316.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>29,316.00</u>	\$ <u>29,316.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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-Beardstown East

0048835 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,428 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

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

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

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

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

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

none

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>40,000</u>	1
2					2
3	TOTALS			\$ <u>40,000</u>	3

Facility Name & ID Number Heritage Manor-Beardstown East

0048835

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	71				\$ 1,744,500	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Shower Remodel		1997	9,921						9
10		Heat/Cool Units		1997	2,138						10
11		Roof		1997	101,691						11
12		Interior Rehab		1997	87,411						12
13											13
14		Five Ton Heat Pump		1996	3,257						14
15		Heritage Manor Sign		1996	2,145						15
16		Remodel Physical Therapy Room		1996	18,303						16
17											17
18		Smoke Detectors		1998	5,431						18
19		Back Flow Preventers		1998	3,155						19
20		Interior Rehab		1998	144,749						20
21											21
22		Water Heater		1999	3,991						22
23		Alzheimer Unit--material		1999	51,576						23
24		Alzheimer Unit--Labor		1999	14,502						24
25		Alzheimer Unit--Professional Fees		1999	21,605						25
26		Interior Rehab		1999	30,944						26
27											27
28		Alzheimer Unit--material		2000	27,447						28
29		Alzheimer Unit--Labor		2000	5,812						29
30		Alzheimer Unit--Professional Fees		2000	1,310						30
31		Fire Alarm Panel		2001	2,026						31
32		Electric Door		2001	2,378						32
33											33
34		C/O Allocation						7,027	7,027		34
35		Book Depreciation				78,970		78,970		830,243	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-Beardstown East

0048835

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	37	
38	Heat/Cool Unit	2002	742					38	
39	Heat/Cool Unit	2002	1,190					39	
40								40	
41	Heat Cool Unit	2003	104					41	
42	Service Sink	2003	691					42	
43	Security System	2003	2,160					43	
44	Compressor	2003	2,244					44	
45	Excerciser Clock	2003	1,243					45	
46	A/C Unit	2003	568					46	
47								47	
48	Carpet	2004	3,280					48	
49	Heat/Cool Unit	2004	2,877					49	
50	Condensing Unit	2004	1,861					50	
51	Electronic Door	2004	624					51	
52								52	
53	Ansul Sustum	2005	2,260					53	
54	Hvac System	2005	2,620					54	
55	Sidewalks	2005	7,106					55	
56	Condensing Unit	2005	3,923					56	
57	Shower repair	2005	320					57	
58								58	
59	condensor	2006	6,350					59	
60	A/C Unit	2006	2,490					60	
61	Fire barriers	2006	2,305					61	
62	Water Heater	2006	3,850					62	
63	Exterior door	2006	105					63	
64	Fire Alarm panel	2006	1,401					64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)		\$ 2,334,606	\$ 78,970		\$ 85,997	\$ 7,027	\$ 830,243	70

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

Facility Name & ID Number Heritage Manor-Beardstown East

0048835

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,334,606	\$ 78,970		\$ 85,997	\$ 7,027	\$ 830,243	1
2									2
3	Exterior Doors	2007	5,289						3
4	Landscaping	2007	15,880						4
5	Dinning Room Paint	2007	1,029						5
6	Fire Barrier	2007	1,703						6
7	Fire Alarm	2007	1,297						7
8	Doors	2007	1,950						8
9	Roof Shingles	2007	4,035						9
10	A/C unit	2007	528						10
11	Water Softener	2007	1,695						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)		\$ 2,368,012	\$ 78,970		\$ 85,997	\$ 7,027	\$ 830,243	34

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

Facility Name & ID Number Heritage Manor-Beardstown East # 0048835 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 286,100	\$ 11,802	\$ 11,802	\$		\$ 249,571	71
72	Current Year Purchases	15,285						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 301,385	\$ 11,802	\$ 11,802	\$		\$ 249,571	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)	\$ 2,709,397	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 90,772	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 97,799	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,027	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,079,814	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: Heritage Manor Real Estate LLC

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:				\$ <u>155,490</u>	<u>5</u>		3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>155,490</u>			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.	<u>/2008</u>	\$ <u>155,490</u>
13.	<u>/2009</u>	\$ <u>155,490</u>
14.	<u>/2010</u>	\$ <u>15,490</u>

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: \$ 2,435 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?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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.

Facility Name & ID Number Heritage Manor-Beardstown East# 0048835

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	\$		\$ 40,201	\$		\$ 40,201	1
2	Licensed Speech and Language Development Therapist		hrs			19,980			19,980	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			41,012	253		41,265	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				125,765		125,765	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					9,134			9,134	13
14	TOTAL			\$		\$ 110,327	\$ 126,018		\$ 236,345	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-Beardstown East# 0048835Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,968	\$	1
2	Cash-Patient Deposits	24,601		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	343,004		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,663		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,988,969)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,602,733)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	2,368,015		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	301,386		16
17	Accumulated Depreciation (book methods)	(1,079,814)		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):	6,937		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,636,524	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 33,791	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 64,484	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,601		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,198		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,888		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,782		32
33	Accrued Interest Payable	4,855		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)	\$ 256,808	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	924,348		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 924,348	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,181,156	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,147,365)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 33,791	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (980,176)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (980,176)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(117,189)	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	(50,000)	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)	\$ (167,189)	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)	\$ (1,147,365)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Beardstown East

0048835

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 2,473,796	1
2	Discounts and Allowances for all Levels	(618,247)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,855,549	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	365,090	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 365,090	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	899	12
13	Barber and Beauty Care	285	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	215,298	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 216,482	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	910	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 910	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)	\$ 2,438,031	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	521,132	31
32	Health Care	1,175,738	32
33	General Administration	665,423	33
B. Capital Expense			
34	Ownership	192,927	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,555,220	40
41	Income before Income Taxes (line 30 minus line 40)**	(117,189)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (117,189)	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-Beardstown East

0048835

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	1,248	1,560	\$ 34,890	\$ 22.37	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,553	4,781	116,241	24.31	3
4	Licensed Practical Nurses	13,202	15,055	244,460	16.24	4
5	CNAs & Orderlies	36,164	38,826	396,628	10.22	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,758	1,919	32,286	16.82	8
9	Activity Director					9
10	Activity Assistants	3,366	3,686	35,179	9.54	10
11	Social Service Workers	1,200	1,200	12,473	10.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,153	14,203	128,889	9.07	15
16	Dishwashers					16
17	Maintenance Workers	1,930	2,184	24,676	11.30	17
18	Housekeepers	7,696	8,331	75,388	9.05	18
19	Laundry	1,908	2,061	20,887	10.13	19
20	Administrator	1,900	2,080	62,413	30.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,019	5,728	64,018	11.18	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)	93,097	101,614	\$ 1,248,428 *	\$ 12.29	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		2,250		36
37	Medical Records Consultant		1,060		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,130		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		2,475		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 7,915		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heritage Manor-Beardstown East

0048835

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	
Pat McNeal	admin		\$ 62,413	Workers' Compensation Insurance	\$ 73,977	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	22,736	Advertising: Employee Recruitment	3,179	
				FICA Taxes	95,505	Health Care Worker Background Check		
				Employee Health Insurance	55,260	(Indicate # of checks performed)	970	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Promotional Advertising	2,886	
					0	Public Relations	5,783	
				Employee Benefits -	26,030	Dues and Subscriptions	5,176	
				Employee Benefits	27,465	License and Fees	6,210	
						Central Office Allocation	4,326	
						Less: Public Relations Expense	(5,783)	
						Non-allowable advertising	(716)	
						Yellow page advertising	(2,886)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
			\$ 62,413		\$ 300,973		\$ 19,145	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Description	Amount	
			\$			Out-of-State Travel	\$	
						In-State Travel		
							0	
							39	
						Seminar Expense	2,978	
							(7,620)	
							6,602	
						Entertainment Expense	()	
						(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL	
			\$		\$		\$ 1,999	
C. Professional Services								
Vendor/Payee	Type		Amount					
Heritage Operations Group			\$ 110,728					
			0					
			0					
			0					
			0					
			1,288					
			0					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
			\$ 112,016					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor-Beardstown East

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? _____
- (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 xx NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Heritage Manor Beardstown East 41632 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,873
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? _____ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
- 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 date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

-

-