

		FOR BHF USE				

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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: 0048843

Facility Name: Heritage Manor-Beardstown South

Address: 8306 St Lukes Drive Beardstown 62618
 Number City Zip Code

County: Cass

Telephone Number: (217) 323-4055 Fax # ()

HFS ID Number: 205300302001

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)
	(Print Name and Title) _____	
	(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 Manor-Beardstown South

0048843 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	79	Skilled (SNF)	79	28,835	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	79	TOTALS	79	28,835	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	11,701	6,254	3,024	20,979	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,701	6,254	3,024	20,979	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.76%

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 _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided 3,024

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 South # 0048843 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	178,292	11,949		190,241		190,241	4,285	194,526		1
2	Food Purchase		189,597		189,597		189,597	17	189,614		2
3	Housekeeping	75,450	10,986		86,436		86,436		86,436		3
4	Laundry	42,732	9,818		52,550		52,550		52,550		4
5	Heat and Other Utilities			206,131	206,131		206,131	1,221	207,352		5
6	Maintenance	76,879	126,835	56,309	260,023		260,023	9,686	269,709		6
7	Other (specify):*										7
8	TOTAL General Services	373,353	349,185	262,440	984,978		984,978	15,209	1,000,187		8
	B. Health Care and Programs										
9	Medical Director							1,534	1,534		9
10	Nursing and Medical Records	859,007	91,113	6,387	956,507		956,507		956,507		10
10a	Therapy		173,984	261,736	435,720	(190,101)	245,619	129,414	375,033		10a
11	Activities	43,262	8,315		51,577		51,577	1,115	52,692		11
12	Social Services	19,993		3,243	23,236		23,236		23,236		12
13	CNA Training		1,351		1,351		1,351	1,420	2,771		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	922,262	274,763	271,366	1,468,391	(190,101)	1,278,290	133,483	1,411,773		16
	C. General Administration										
17	Administrative	74,589			74,589		74,589	50,829	125,418		17
18	Directors Fees							4,523	4,523		18
19	Professional Services			166,363	166,363		166,363	(156,020)	10,343		19
20	Dues, Fees, Subscriptions & Promotions			105,583	105,583	(43,253)	62,330	(16,450)	45,880		20
21	Clerical & General Office Expenses	98,479	17,656	12,727	128,862		128,862	111,588	240,450		21
22	Employee Benefits & Payroll Taxes			318,662	318,662		318,662	30,560	349,222		22
23	Inservice Training & Education			1,683	1,683		1,683	316	1,999		23
24	Travel and Seminar			4,527	4,527		4,527	(2,528)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			65,847	65,847		65,847	4,505	70,352		26
27	Other (specify):*			7,770	7,770		7,770	(7,770)			27
28	TOTAL General Administration	173,068	17,656	683,162	873,886	(43,253)	830,633	19,553	850,186		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,468,683	641,604	1,216,968	3,327,255	(233,354)	3,093,901	168,245	3,262,146		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 South #0048843 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			128,790	128,790		128,790	(8,404)	120,386		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			145,274	145,274		145,274	4,152	149,426		32
33	Real Estate Taxes			55,812	55,812		55,812		55,812		33
34	Rent-Facility & Grounds							4,775	4,775		34
35	Rent-Equipment & Vehicles			(647)	(647)		(647)	1,300	653		35
36	Other (specify):*										36
37	TOTAL Ownership			329,229	329,229		329,229	1,823	331,052		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					190,101	190,101		190,101		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					43,253	43,253		43,253		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers					233,354	233,354		233,354		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,468,683	641,604	1,546,197	3,656,484		3,656,484	170,068	3,826,552		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 South

0048843

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	(16,223)	30		9
10	Interest and Other Investment Income	(1,131)	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	(379)	20		17
18	Fines and Penalties				18
19	Entertainment	(9,874)	24		19
20	Contributions	(1,770)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,129)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	27		24
25	Fund Raising, Advertising and Promotional	(20,884)	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)	\$ (58,390)		\$	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)	228,458		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 228,458		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 170,068		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 South

ID# 0048843

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		(16,223)	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(379)	20
18			18
19			24
20		(1,770)	27
21			21
22		(2,129)	19
23			23
24		(6,000)	27
25		(20,884)	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	(47,385)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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	4,285	0	0	0	0	0	0	0	0	4,285	1
2	Food Purchase	0	0	17	0	0	0	0	0	0	0	0	17	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	1,221	0	0	0	0	0	0	0	0	1,221	5
6	Maintenance	0	0	9,686	0	0	0	0	0	0	0	0	9,686	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	15,209	0	0	0	0	0	0	0	0	15,209	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,534	0	0	0	0	0	0	0	0	1,534	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	129,414	0	0	0	0	0	0	0	0	0	129,414	10a
11	Activities	0	0	1,115	0	0	0	0	0	0	0	0	1,115	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,420	0	0	0	0	0	0	0	0	1,420	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	129,414	4,069	0	0	0	0	0	0	0	0	133,483	16
	C. General Administration													
17	Administrative	0	0	50,829	0	0	0	0	0	0	0	0	50,829	17
18	Directors Fees	0	0	4,523	0	0	0	0	0	0	0	0	4,523	18
19	Professional Services	(2,129)	(160,248)	6,357	0	0	0	0	0	0	0	0	(156,020)	19
20	Fees, Subscriptions & Promotions	(21,263)	0	4,813	0	0	0	0	0	0	0	0	(16,450)	20
21	Clerical & General Office Expenses	0	0	111,588	0	0	0	0	0	0	0	0	111,588	21
22	Employee Benefits & Payroll Taxes	0	0	30,560	0	0	0	0	0	0	0	0	30,560	22
23	Inservice Training & Education	0	0	316	0	0	0	0	0	0	0	0	316	23
24	Travel and Seminar	(9,874)	0	7,346	0	0	0	0	0	0	0	0	(2,528)	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	4,505	0	0	0	0	0	0	0	0	4,505	26
27	Other (specify):*	(7,770)	0	0	0	0	0	0	0	0	0	0	(7,770)	27
28	TOTAL General Administration	(41,036)	(160,248)	220,837	0	0	0	0	0	0	0	0	19,553	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(41,036)	(30,834)	240,115	0	0	0	0	0	0	0	0	168,245	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(16,223)	0	0	7,819	0	0	0	0	0	0	0	(8,404)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,131)	0	0	5,283	0	0	0	0	0	0	0	4,152	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	4,775	0	0	0	0	0	0	0	4,775	34
35	Rent-Equipment & Vehicles	0	0	0	1,300	0	0	0	0	0	0	0	1,300	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,354)	0	0	19,177	0	1,823	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)	(58,390)	(30,834)	240,115	19,177	0	170,068	45						

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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		\$			\$	\$	1
2	V	10a Adjustment for Related Organization						2
3	V							3
4	V	19 Adjustment for Related Organization	160,248	Heritage Enterprises, Inc.			(160,248)	4
5	V							5
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		129,414	129,414	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 160,248			\$ 129,414	\$ * (30,834)	14

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

Facility Name & ID Number Heritage Manor-Beardstown South# 0048843Report 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%	\$	4,285	15
16	V	2 Food Purchase					17	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,221	19
20	V	6 Maintenance					9,686	20
21	V	7 Other					0	21
22	V	9 Medical Director					1,534	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					1,115	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,420	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					50,829	29
30	V	18 Directors Fees					4,523	30
31	V	19 Professional Services					6,357	31
32	V	20 Fees, Subscription, Promotions					4,813	32
33	V	21 Clerical & General Office Expenses					111,588	33
34	V	22 Employee Benefits & Payroll Taxes					30,560	34
35	V	23 Inservice Training & Education					316	35
36	V	24 Travel and Seminar					7,346	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					4,505	38
39	Total		\$			\$	0	\$ * 240,115 39

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

Facility Name & ID Number Heritage Manor-Beardstown South# 0048843Report 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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	27	Other	\$		100.00%	\$	0	15
16	V	30	Depreciation					7,819	16
17	V	31	Amortization of Pre-Op & Org						17
18	V	32	Interest					5,283	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					4,775	20
21	V	35	Rent-Equipment & Vehicles					1,300	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	\$ * 19,177 39

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

Facility Name & ID Number Heritage Manor-Beardstown South # 0048843 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					\$ 4,523	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	\$ 4,523		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 South

0048843

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	79	\$ 4,285	1
2	2	Food Purchase	Beds	2,624	25	577	0	79	17	2
3	3	Housekeeping	Beds	2,624	25	0	0	79	0	3
4	4	Laundry	Beds	2,624	25	0	0	79	0	4
5	5	Heat & Other Utilities	Beds	2,624	25	40,565	0	79	1,221	5
6	6	Maintenance	Beds	2,624	25	321,709	65,509	79	9,686	6
7	7	Other	Beds	2,624	25	0	0	79	0	7
8	9	Medical Director	Beds	2,624	25	50,960	0	79	1,534	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	56,488	79	0	9
10	11	Activities	Beds	2,624	25	37,038	36,931	79	1,115	10
11	12	Social Service	Beds	2,624	25	0	0	79	0	11
12	13	Nurse Aide Training	Beds	2,624	25	47,168	47,168	79	1,420	12
13	14	Program Transportation	Beds	2,624	25	0	0	79	0	13
14	15	Other	Beds	2,624	25	0	0	79	0	14
15	17	Administrative	Beds	2,624	25	1,688,288	1,688,288	79	50,829	15
16	18	Directors Fees	Beds	2,624	25	150,218	0	79	4,523	16
17	19	Professional Services	Beds	2,624	25	211,148	0	79	6,357	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	159,872	0	79	4,813	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,706,408	3,356,042	79	111,588	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	1,015,049	0	79	30,560	20
21	23	Inservice Training & Education	Beds	2,624	25	10,511	0	79	316	21
22	24	Travel and Seminar	Beds	2,624	25	243,988	0	79	7,346	22
23	25	Other Admin. Staff Transportatio	Beds	2,624	25	0	0	79	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,624	25	149,629	0	79	4,505	24
25	TOTALS					\$ 7,975,470	\$ 5,392,483		\$ 240,115	25

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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	\$	79	\$	1
2	30	Depreciation	Beds	2,624	25	259,703	79	7,819	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		79		3
4	32	Interest	Beds	2,624	25	175,477	79	5,283	4
5	33	Real Estate Taxes	Beds	2,624	25		79		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587	79	4,775	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166	79	1,300	7
8	36	Other	Beds	2,624	25		79		8
9	38	Medically Nec Transportation	Beds	2,624	25		79		9
10	39	Ancillary Service Centers	Beds	2,624	25		79		10
11	40	Barber and Beauty Shops	Beds	2,624	25		79		11
12	41	Coffee and Gift Shops	Beds	2,624	25		79		12
13	42	Other	Beds	2,624	25		79		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	\$		\$ 19,177	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LsSalle National Bank		xx	Mortgage			\$	\$ 2,466,297		\$ 122,682	1									
2	LsSalle National Bank		xx	Mortgage						11,718	2									
3											3									
4											4									
5											5									
Working Capital																				
6	LsSalle National Bank		xx	Working Capital						10,874	6									
7	LsSalle National Bank		xx								7									
8											8									
9	TOTAL Facility Related						\$	\$ 2,466,297		\$ 145,274	9									
B. Non-Facility Related*																				
10	Interest Income									(1,131)	10									
11	Allocated Corporate									5,283	11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ 4,152	14									
15	TOTALS (line 9+line14)						\$	\$ 2,466,297		\$ 149,426	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.)

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 South COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0048843

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>03-011-012-01</u>	<u>nursing home</u>	\$ <u>4,941.00</u>	\$ <u>4,941.00</u>
2. <u>03-011-012-00</u>	<u></u>	\$ <u>55,375.00</u>	\$ <u>55,375.00</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>60,316.00</u>	\$ <u>60,316.00</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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,196 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>25,000</u>	1
2					2
3	TOTALS			\$ <u>25,000</u>	3

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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	79				\$ 1,380,638	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Remodel facility--Materials		1997	282,659						9
10		Remodel facility--Labor		1997	59,019						10
11		Nurse Call System		1997	1,500						11
12											12
13		Remodel facility--Materials		1998	83,670						13
14		Remodel facility--Labor		1998	9,606						14
15		Laundry Room Remodel-Materials		1998	17,292						15
16		Laundry Room Remodel-Labor		1998	1,367						16
17		UST Removal/AST Installation		1998	6,992						17
18		A/C Compressor		1998	9,465						18
19											19
20		Assisted Living Labor		1998	192						20
21		Assisted Living Professional Fees		1998	4,128						21
22											22
23		Assisted Living --Labor		1999	113,254						23
24		Assisted Living --Professional Fees		1999	28,883						24
25		Assisted Living --Materials		1999	502,491						25
26											26
27		Door Alarm System		2000	2,727						27
28		A/C Compressor		2000	2,984						28
29		Compressor -- Walk-in Freezer		2000	2,586						29
30		Water Heater		2000	2,804						30
31		Assisted Living --Professional Fees		2000	3,356						31
32		1st Floor Room Remodel --Labor and Materials		2000	16,618						32
33								(16,223)	(16,223)		33
34		C/O Allocation						7,819	7,819		34
35		Book Depreciation				106,393		106,393		903,482	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 South

0048843

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	
37	Recirculating Pump	2001	\$ 889	\$		\$	\$	\$	37
38	West entrance Door	2001	1,700						38
39									39
40	Door	2002	2,840						40
41	a/c unit	2002	15,900						41
42	Shower room Wall	2002	1,200						42
43	Cmpressor	2002	13,348						43
44	Alzheimers Unit--Farnworth	2002	2,415						44
45	Sewer Relocation	2002	2,011						45
46									46
47	Sewer Relocation	2003	2,206						47
48	a/c units	2003	10,170						48
49	Computer Board	2003	1,081						49
50	Disposer	2003	1,454						50
51	A/C Unit	2003	5,786						51
52	Rebuild Generator	2003	4,276						52
53									53
54	Exterior doors	2004	3,212						54
55	Shower room Remodel	2004	9,028						55
56	Landscapping	2004	3,030						56
57	Canopy	2004	570						57
58	Door	2004	1,068						58
59	A/C Unit	2004	7,326						59
60	Heat/Cool Units	2004	6,960						60
61	Carpet	2004	911						61
62	Compressor	2004	2,949						62
63	Chiller	2004	1,970						63
64	Drier Core	2004	953						64
65									65
66									66
67									67
68	Wallguard/Wallcoverings								68
69	Carpet								69
70	TOTAL (lines 4 thru 69)		\$ 2,635,484	\$ 106,393		\$ 97,989	\$ (8,404)	\$ 903,482	70

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

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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		\$ 2,635,484	\$ 106,393		\$ 97,989	\$ (8,404)	\$ 903,482	1
2		2005	7,273						2
3	Shower Remodel	2005	2,540						3
4	Ansul System	2005	1,070						4
5	Chemical Flush	2005	735						5
6	A/C	2005	37,498						6
7	Interior rehab -- Labor and Materials	2005	2,092						7
8	Delayed Egress Magnet	2005	2,125						8
9	Panic Door Hardware	2005	3,702						9
10	Roof repair	2005	11,067						10
11	A/C repairs --assisted living								11
12		2006	2,445						12
13	Door opener	2006	2,267						13
14	Wanderguard system	2006	13,771						14
15	Hot water heater	2006	4,928						15
16	Sidewalk	2006	13,365						16
17	compressor	2006	17,853						17
18	Hvac	2006	370						18
19	Exterior door	2006	6,568						19
20	Alarm system	2006	1,727						20
21	Generater regulator	2006	4,264						21
22	Awning	2006	2,722						22
23	Closet door								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)		\$ 2,773,866	\$ 106,393		\$ 97,989	\$ (8,404)	\$ 903,482	34

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

Facility Name & ID Number Heritage Manor-Beardstown South

0048843

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 12B, Carried Forward		\$ 2,773,866	\$ 106,393		\$ 97,989	\$ (8,404)	\$ 903,482	1
2									2
3	Exterior doors	2007	1,100						3
4	Condensor	2007	5,302						4
5	Carpet -- chapel	2007	4,500						5
6	Exterior doors	2007	3,169						6
7	Awning	2007	533						7
8	Fan motor	2007	1,811						8
9	Thermostats	2007	1,154						9
10	Hallway wiring	2007	1,396						10
11	HVAC	2007	9,672						11
12	Chiller	2007	6,226						12
13	Landscapping	2007	35,000						13
14	Water Heater	2007	21,682						14
15	Rooftop A/C	2007	205						15
16	Blinds	2007	845						16
17	Roof fans	2007	3,457						17
18	A/C	2007	12,487						18
19	Doors	2007	3,358						19
20	Generator	2007	39,004						20
21	Wall Heater	2007	3,384						21
22	Circulating pump	2007	896						22
23	Roof	2007	141,801						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)		\$ 3,070,848	\$ 106,393		\$ 97,989	\$ (8,404)	\$ 903,482	34

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

Facility Name & ID Number Heritage Manor-Beardstown South # 0048843 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	\$ 678,016	\$ 22,397	\$ 22,397	\$		\$ 613,878	71
72	Current Year Purchases	23,224						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 701,240	\$ 22,397	\$ 22,397	\$		\$ 613,878	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	3,797,088	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	128,790	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	120,386	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	(8,404)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,517,360	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:		79		\$ 229,950	5		3
4	Additions							4
5								5
6								6
7	TOTAL		79		\$ 229,950			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>229,950</u>
13.	<u>/2009</u>	\$ <u>229,950</u>
14.	<u>/2010</u>	\$ <u>229,950</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: \$ 653 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,351		1,351
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	\$	\$ 1,351	\$	\$ 1,351
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,351		

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 112,348	\$		\$ 112,348	1
2	Licensed Speech and Language Development Therapist		hrs			22,175			22,175	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			110,018	1,078		111,096	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				172,906		172,906	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					17,195			17,195	13
14	TOTAL			\$		\$ 261,736	\$ 173,984		\$ 435,720	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 South# 0048843Report 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	\$ 13,828	\$	1
2	Cash-Patient Deposits	9,464		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	379,337		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,285		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	296,588		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 728,502	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	3,070,849		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	701,239		16
17	Accumulated Depreciation (book methods)	(1,517,359)		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):	16,389		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,296,118	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,024,620	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 245,880	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,464		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	145,043		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,528		31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,333		32
33	Accrued Interest Payable	14,502		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)	\$ 494,750	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,466,297		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)	\$ 2,466,297	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,961,047	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 63,573	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,024,620	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 223,139	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 223,139	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(134,566)	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	(25,000)	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)	\$ (159,566)	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)	\$ 63,573	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Beardstown South# 0048843Report Period Beginning: 01/01/07Ending: 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	\$ 3,103,691	1
2	Discounts and Allowances for all Levels	(1,127,026)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,976,665	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	910,580	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 910,580	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	682	12
13	Barber and Beauty Care	1,024	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	28,052	16
17	Sale of Drugs	294,760	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)	\$ 324,518	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,131	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,131	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		(4,550)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (4,550)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,208,344	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	984,978	31
32	Health Care	1,468,391	32
33	General Administration	873,886	33
B. Capital Expense			
34	Ownership	329,229	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	<u>non nursing home</u>	(313,574)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,342,910	40
41	Income before Income Taxes (line 30 minus line 40)**	(134,566)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (134,566)	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 South

0048843

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	1,856	2,080	\$ 52,143	\$ 25.07	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	548	548	9,448	17.24	3
4	Licensed Practical Nurses	16,593	18,169	311,040	17.12	4
5	CNAs & Orderlies	39,807	42,495	462,064	10.87	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,798	1,971	24,312	12.33	8
9	Activity Director					9
10	Activity Assistants	3,853	4,098	43,262	10.56	10
11	Social Service Workers	1,413	1,629	19,993	12.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,555	18,447	178,292	9.67	15
16	Dishwashers					16
17	Maintenance Workers	4,262	4,817	76,879	15.96	17
18	Housekeepers	10,426	11,135	75,450	6.78	18
19	Laundry	1,856	2,349	42,732	18.19	19
20	Administrator	1,900	2,080	74,589	35.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,711	8,386	98,479	11.74	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)	109,578	118,204	\$ 1,468,683 *	\$ 12.42	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		0		36
37	Medical Records Consultant		1,457		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,150		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,243		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 7,850		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	25	\$ 1,016		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)	25	\$ 1,016		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? _____
- (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 38273 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 43,253
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.

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