

		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:** 0048850

**Facility Name:** Heritage Manor-Carlinville

**Address:** 1200 University Avenue Carlinville 62626  
 Number City Zip Code

**County:** Macoupin

**Telephone Number:** ( 217 ) 854-4433 Fax # ( )

**HFS ID Number:** 205508113001

**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
<b>IRS Exemption Code</b> _____	<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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	<u>04/15/08</u>
	(Type or Print Name) <u>Craig Ater</u>	(Date)
<b>Paid Preparer</b>	(Title) <u>Sr. VP &amp; CFO</u>	
	(Signed) _____	(Date)
<b>Paid Preparer</b>	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____	Fax # ( ) _____
	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>	

Phone # (217) 782-1630

Facility Name & ID Number Heritage Manor-Carlinville

# 0048850 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	108	Skilled (SNF)	108	39,420	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	108	TOTALS	108	39,420	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	15,265	10,698	3,612	29,575	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,265	10,698	3,612	29,575	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.03%

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 3,612

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-Carlinville # 0048850 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
	<b>A. General Services</b>										
1	Dietary	158,804	9,789		168,593		168,593	5,859	174,452		1
2	Food Purchase		158,765		158,765		158,765	24	158,789		2
3	Housekeeping	70,658	16,877		87,535		87,535		87,535		3
4	Laundry	47,501	13,697		61,198		61,198		61,198		4
5	Heat and Other Utilities			104,973	104,973		104,973	1,670	106,643		5
6	Maintenance	43,155	38,209	29,489	110,853		110,853	13,241	124,094		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>320,118</b>	<b>237,337</b>	<b>134,462</b>	<b>691,917</b>		<b>691,917</b>	<b>20,794</b>	<b>712,711</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,000	3,000		3,000	2,097	5,097		9
10	Nursing and Medical Records	1,304,620	74,497	16,778	1,395,895		1,395,895		1,395,895		10
10a	Therapy		301,459	374,551	676,010	(317,724)	358,286	290,503	648,789		10a
11	Activities	53,773	1,444		55,217		55,217	1,524	56,741		11
12	Social Services	27,172		3,378	30,550		30,550		30,550		12
13	CNA Training		3,923		3,923		3,923	1,941	5,864		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,385,565</b>	<b>381,323</b>	<b>397,707</b>	<b>2,164,595</b>	<b>(317,724)</b>	<b>1,846,871</b>	<b>296,065</b>	<b>2,142,936</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	62,483			62,483		62,483	69,487	131,970		17
18	Directors Fees							6,183	6,183		18
19	Professional Services			190,377	190,377		190,377	(180,638)	9,739		19
20	Dues, Fees, Subscriptions & Promotions			89,267	89,267	(59,130)	30,137	(5,835)	24,302		20
21	Clerical & General Office Expenses	140,444	14,911	13,056	168,411		168,411	152,550	320,961		21
22	Employee Benefits & Payroll Taxes			433,612	433,612		433,612	41,778	475,390		22
23	Inservice Training & Education			1,493	1,493		1,493	433	1,926		23
24	Travel and Seminar			3,208	3,208		3,208	(1,209)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			70,884	70,884		70,884	6,159	77,043		26
27	Other (specify):*			26,000	26,000		26,000	(26,000)			27
28	<b>TOTAL General Administration</b>	<b>202,927</b>	<b>14,911</b>	<b>827,897</b>	<b>1,045,735</b>	<b>(59,130)</b>	<b>986,605</b>	<b>62,908</b>	<b>1,049,513</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,908,610</b>	<b>633,571</b>	<b>1,360,066</b>	<b>3,902,247</b>	<b>(376,854)</b>	<b>3,525,393</b>	<b>379,767</b>	<b>3,905,160</b>		<b>29</b>

\*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-Carlinville

#0048850

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	
	<b>D. Ownership</b>											
30	Depreciation			127,298	127,298		127,298	10,689	137,987			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			146,970	146,970		146,970	4,701	151,671			32
33	Real Estate Taxes			40,216	40,216		40,216		40,216			33
34	Rent-Facility & Grounds							6,527	6,527			34
35	Rent-Equipment & Vehicles			8,630	8,630		8,630	1,777	10,407			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			323,114	323,114		323,114	23,694	346,808			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					317,724	317,724		317,724			39
40	Barber and Beauty Shops		344	8,284	8,628		8,628		8,628			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					59,130	59,130		59,130			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		344	8,284	8,628	376,854	385,482		385,482			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,908,610	633,915	1,691,464	4,233,989		4,233,989	403,461	4,637,450			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-Carlinville

# 0048850

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	(2,521)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,464)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,251)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(275)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,000)	27		24
25	Fund Raising, Advertising and Promotional	(10,951)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (52,462)		\$	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)	455,923		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 455,923		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 403,461		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	
				51	
					52

Heritage Manor-Carlinville

ID# 0048850

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		(1,464)	20
18			18
19			24
20		0	27
21			21
22		(275)	19
23			23
24		(26,000)	27
25		(10,951)	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	<b>Total</b>	(38,690)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Carlinville

# 0048850

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)	
	<b>A. General Services</b>													
1	Dietary	0	0	5,859	0	0	0	0	0	0	0	0	5,859	1
2	Food Purchase	0	0	24	0	0	0	0	0	0	0	0	24	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	1,670	0	0	0	0	0	0	0	0	1,670	5
6	Maintenance	0	0	13,241	0	0	0	0	0	0	0	0	13,241	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	20,794	0	0	0	0	0	0	0	0	20,794	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	2,097	0	0	0	0	0	0	0	0	2,097	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	290,503	0	0	0	0	0	0	0	0	0	290,503	10a
11	Activities	0	0	1,524	0	0	0	0	0	0	0	0	1,524	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,941	0	0	0	0	0	0	0	0	1,941	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	290,503	5,562	0	0	0	0	0	0	0	0	296,065	16
	<b>C. General Administration</b>													
17	Administrative	0	0	69,487	0	0	0	0	0	0	0	0	69,487	17
18	Directors Fees	0	0	6,183	0	0	0	0	0	0	0	0	6,183	18
19	Professional Services	(275)	(189,054)	8,691	0	0	0	0	0	0	0	0	(180,638)	19
20	Fees, Subscriptions & Promotions	(12,415)	0	6,580	0	0	0	0	0	0	0	0	(5,835)	20
21	Clerical & General Office Expenses	0	0	152,550	0	0	0	0	0	0	0	0	152,550	21
22	Employee Benefits & Payroll Taxes	0	0	41,778	0	0	0	0	0	0	0	0	41,778	22
23	Inservice Training & Education	0	0	433	0	0	0	0	0	0	0	0	433	23
24	Travel and Seminar	(11,251)	0	10,042	0	0	0	0	0	0	0	0	(1,209)	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	6,159	0	0	0	0	0	0	0	0	6,159	26
27	Other (specify):*	(26,000)	0	0	0	0	0	0	0	0	0	0	(26,000)	27
28	<b>TOTAL General Administration</b>	(49,941)	(189,054)	301,903	0	0	0	0	0	0	0	0	62,908	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(49,941)	101,449	328,259	0	0	0	0	0	0	0	0	379,767	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Carlinville

# 0048850

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	0	0	0	10,689	0	0	0	0	0	0	0	10,689	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,521)	0	0	7,222	0	0	0	0	0	0	0	4,701	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	6,527	0	0	0	0	0	0	0	6,527	34
35	Rent-Equipment & Vehicles	0	0	0	1,777	0	0	0	0	0	0	0	1,777	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,521)</b>	<b>0</b>	<b>0</b>	<b>26,215</b>	<b>0</b>	<b>23,694</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(52,462)</b>	<b>101,449</b>	<b>328,259</b>	<b>26,215</b>	<b>0</b>	<b>403,461</b>	<b>45</b>						

Facility Name & ID Number Heritage Manor-Carlinville

# 0048850

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:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V		\$			\$	\$
2	V	10a Adjustment for Related Organization					
3	V						
4	V	19 Adjustment for Related Organization	189,054	Heritage Enterprises, Inc.			(189,054)
5	V						
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		290,503	290,503
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 189,054			\$ 290,503	\$ * 101,449

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

Facility Name & ID Number Heritage Manor-Carlinville# 0048850Report 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%	\$	5,859	15
16	V	2 Food Purchase					24	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,670	19
20	V	6 Maintenance					13,241	20
21	V	7 Other					0	21
22	V	9 Medical Director					2,097	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					1,524	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,941	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					69,487	29
30	V	18 Directors Fees					6,183	30
31	V	19 Professional Services					8,691	31
32	V	20 Fees, Subscription, Promotions					6,580	32
33	V	21 Clerical & General Office Expenses					152,550	33
34	V	22 Employee Benefits & Payroll Taxes					41,778	34
35	V	23 Inservice Training & Education					433	35
36	V	24 Travel and Seminar					10,042	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					6,159	38
39	Total		\$			\$	0	\$ * 328,259 39

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

Facility Name & ID Number Heritage Manor-Carlinville# 0048850Report 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					10,689	16
17	V	31	Amortization of Pre-Op & Org						17
18	V	32	Interest					7,222	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,527	20
21	V	35	Rent-Equipment & Vehicles					1,777	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	\$ * 26,215 39

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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					\$ 6,183	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	\$ 6,183		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-Carlinville

# 0048850

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	108	\$ 5,859	1
2	2	Food Purchase	Beds	2,624	25	577	0	108	24	2
3	3	Housekeeping	Beds	2,624	25	0	0	108	0	3
4	4	Laundry	Beds	2,624	25	0	0	108	0	4
5	5	Heat & Other Utilities	Beds	2,624	25	40,565	0	108	1,670	5
6	6	Maintenance	Beds	2,624	25	321,709	65,509	108	13,241	6
7	7	Other	Beds	2,624	25	0	0	108	0	7
8	9	Medical Director	Beds	2,624	25	50,960	0	108	2,097	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	56,488	108	0	9
10	11	Activities	Beds	2,624	25	37,038	36,931	108	1,524	10
11	12	Social Service	Beds	2,624	25	0	0	108	0	11
12	13	Nurse Aide Training	Beds	2,624	25	47,168	47,168	108	1,941	12
13	14	Program Transportation	Beds	2,624	25	0	0	108	0	13
14	15	Other	Beds	2,624	25	0	0	108	0	14
15	17	Administrative	Beds	2,624	25	1,688,288	1,688,288	108	69,487	15
16	18	Directors Fees	Beds	2,624	25	150,218	0	108	6,183	16
17	19	Professional Services	Beds	2,624	25	211,148	0	108	8,691	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	159,872	0	108	6,580	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,706,408	3,356,042	108	152,550	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	1,015,049	0	108	41,778	20
21	23	Inservice Training & Education	Beds	2,624	25	10,511	0	108	433	21
22	24	Travel and Seminar	Beds	2,624	25	243,988	0	108	10,042	22
23	25	Other Admin. Staff Transportatio	Beds	2,624	25	0	0	108	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,624	25	149,629	0	108	6,159	24
25	TOTALS					\$ 7,975,470	\$ 5,392,483		\$ 328,259	25

Facility Name & ID Number Heritage Manor-Carlinville

# 0048850

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	\$	108	\$	1
2	30	Depreciation	Beds	2,624	25	259,703	108	10,689	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		108		3
4	32	Interest	Beds	2,624	25	175,477	108	7,222	4
5	33	Real Estate Taxes	Beds	2,624	25		108		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587	108	6,527	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166	108	1,777	7
8	36	Other	Beds	2,624	25		108		8
9	38	Medically Nec Transportation	Beds	2,624	25		108		9
10	39	Ancillary Service Centers	Beds	2,624	25		108		10
11	40	Barber and Beauty Shops	Beds	2,624	25		108		11
12	41	Coffee and Gift Shops	Beds	2,624	25		108		12
13	42	Other	Beds	2,624	25		108		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	\$	\$ 26,215	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	LsSalle National Bank		xx	Mortgage			\$	\$ 930,992		\$ 120,051	1									
2	LsSalle National Bank		xx	Mortgage						12,029	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	LsSalle National Bank		xx	Working Capital						14,890	6									
7	LsSalle National Bank		xx								7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$ 930,992		\$ 146,970	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income									(2,521)	10									
11	Allocated Corporate									7,222	11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ 4,701	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 930,992		\$ 151,671	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-Carlinville COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0048850

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>12-000-264-02</u>	<u>nursing home</u>	\$ <u>40,390.00</u>	\$ <u>40,390.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>40,390.00</u>	\$ <u>40,390.00</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-Carlinville# 0048850 Report Period Beginning:01/01/07 Ending:12/31/07**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 14,527 B. General Construction Type: Exterior brick Frame wood Number of Stories 1C. 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).

noneF. 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>32,017</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>32,017</u>	3

Facility Name & ID Number Heritage Manor-Carlinville

# 0048850

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	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	108			\$ 3,265,145	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Heritage Manor Sign		1996	2,176						9
10	Architect Fees		1996	2,387						10
11	Laundry Room Electrical Repair		1996	3,019						11
12										12
13										13
14	Special Care Unit -- Remodel		1997	30,884						14
15										15
16	Remodel-- Alzheimer Wing		1998	78,813						16
17	A/C Unit		1998	950						17
18	Life Safety Improvements		1998	7,351						18
19	Shower Room Remodel		1998	2,811						19
20	Roof Replacement		1998	92,246						20
21										21
22	Door Alarm		1999	2,317						22
23	Smoke Damperer		1999	498						23
24	Water System		1999	8,115						24
25	Interior Painting--Material and Labor		1999	6,892						25
26	Shower Room Remodel		1999	2,453						26
27	Water Heater		1999	4,253						27
28										28
29										29
30										30
31										31
32										32
33										33
34	C/O Allocation						10,689	10,689		34
35	Book Depreciation				102,283		102,283		1,070,746	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-Carlinville# 0048850

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	Water Softener	2000	\$ 3,802	\$		\$	\$	\$	37
38	Shower room Remodel ---Material and Labor	2000	3,608						38
39	A/C Rooftop Unit	2000	12,490						39
40	Pipe --Hallway Floor	2000	1,920						40
41									41
42	Electric Heater	2001	4,700						42
43									43
44	A/C Rooftop Unit-(remove)	2002	(12,490)						44
45	Heat / Cool Unit	2002	8,969						45
46	Floor Coverings	2002	6,638						46
47	Roof top unit	2002	4,995						47
48	Roof top unit	2002	2,918						48
49									49
50	Floor coverings	2003	11,232						50
51	Resurface parking lot	2003	25,786						51
52	A/C unit	2003	11,167						52
53	Dishwasher	2003	3,880						53
54	Boiler	2003	1,978						54
55	Backflow unit	2003	740						55
56	Heat / Cool Unit	2003	5,607						56
57									57
58	Hot Water Pump	2004	750						58
59	Heat / Cool Unit	2004	4,485						59
60	Booster Heater	2004	2,261						60
61	Door Closer	2004	578						61
62	A/C Unit	2004	1,101						62
63	Roof top unit	2004	3,504						63
64	Electric Heater	2004	13,454						64
65	Secure Care System	2004	3,053						65
66	Ansul System	2004	1,685						66
67									67
68	Wallguard/Wallcoverings								68
69	Carpet								69
70	TOTAL (lines 4 thru 69)		\$ 3,639,121	\$ 102,283		\$ 112,972	\$ 10,689	\$ 1,070,746	70

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

Facility Name &amp; ID Number Heritage Manor-Carlinville

# 0048850

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		\$ 3,639,121	\$ 102,283		\$ 112,972	\$ 10,689	\$ 1,070,746	1
2									2
3	Window Replacement	2005	371						3
4	HVAC	2005	10,165						4
5	Rooftop A/C	2005	8,997						5
6	Water Storage Tank	2005	4,456						6
7	Rooftop Heater	2005	3,425						7
8									8
9	Sidewalk	2006	630						9
10	Parking Lot Sealer	2006	2,385						10
11	Window Replacement	2006	1,638						11
12	Resident room remodel -- paint, wall coverings	2006	9,197						12
13	Smoke detectors	2006	1,644						13
14									14
15	Resident room remodel -- paint, wall coverings	2007	4,459						15
16	Corridor Rehab -- Paint/Wallpaper	2007	23,721						16
17	HVAC	2007	9,819						17
18	Fire Alarm	2007	2,900						18
19	Rosedale Corridor Rehab-- Paint/ Wallpaper	2007	5,027						19
20	Sprinkler System	2007	3,398						20
21	Heat Detector	2007	2,091						21
22	Landscaping	2007	4,999						22
23	Rosedale Resident room Rehab -- Paint/Wallpaper	2007	32,026						23
24	Rooftop A/C	2007	4,417						24
25	Kitchen Repairs	2007	2,512						25
26	Asbestos Sample	2007	545						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,777,943	\$ 102,283		\$ 112,972	\$ 10,689	\$ 1,070,746	34

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 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	\$ 507,368	\$ 25,015	\$ 25,015	\$		\$ 404,245	71
72	Current Year Purchases	60,475						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 567,843	\$ 25,015	\$ 25,015	\$		\$ 404,245	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)	\$ 4,377,803	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 127,298	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 137,987	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,689	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,474,991	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>236,520</u>	<u>5</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ <u>236,520</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>236,520</u>
13.	<u>/2009</u>	\$ <u>236,520</u>
14.	<u>/2010</u>	\$ <u>236,520</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: \$ 10,407 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	<b>TOTAL</b>		\$ _____	\$ _____	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		3,923		3,923
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	\$	\$ 3,923	\$	\$ 3,923
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,923		

**C. CONTRACTUAL INCOME**

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

\$ \_\_\_\_\_

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 170,132	\$		\$ 170,132	1
2	Licensed Speech and Language Development Therapist		hrs			20,422			20,422	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			166,972	760		167,732	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				300,699		300,699	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					17,025			17,025	13
14	<b>TOTAL</b>			\$		\$ 374,551	\$ 301,459		\$ 676,010	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-Carlinville # 0048850 Report 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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 17,640	\$	1
2	Cash-Patient Deposits	35,475		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	457,556		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,769		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(3,414,709)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (2,888,269)	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,017		13
14	Buildings, at Historical Cost	3,777,942		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	567,844		16
17	Accumulated Depreciation (book methods)	(1,474,991)		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):	17,260		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,920,072	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 31,803	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 137,803	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,475		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	231,613		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,420		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,410		32
33	Accrued Interest Payable	5,434		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 456,155	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	930,992		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 930,992	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,387,147	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,355,344)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 31,803	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,500,836)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,500,836)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	245,492	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	(100,000)	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)	\$ 145,492	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (1,355,344)	24 *

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

Facility Name & ID Number Heritage Manor-Carlinville# 0048850Report 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,216,174	1
2	Discounts and Allowances for all Levels	(1,563,222)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,652,952</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,278,289	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,278,289</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	(50)	11
12	Gift and Coffee Shop	1,705	12
13	Barber and Beauty Care	12,209	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	534,390	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 548,254</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	(14)	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ (14)</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,479,481</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	691,917	31
32	Health Care	2,164,595	32
33	General Administration	1,045,735	33
<b>B. Capital Expense</b>			
34	Ownership	323,114	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	8,628	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,233,989</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>245,492</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 245,492</b>	<b>43</b>

\* 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-Carlinville

# 0048850

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	1,686	1,935	\$ 50,864	\$ 26.29	1
2	Assistant Director of Nursing	925	1,673	23,159	13.84	2
3	Registered Nurses	2,550	2,659	78,134	29.38	3
4	Licensed Practical Nurses	17,018	18,656	374,364	20.07	4
5	CNAs & Orderlies	66,403	71,922	754,285	10.49	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,583	1,963	23,814	12.13	8
9	Activity Director					9
10	Activity Assistants	5,063	5,478	53,773	9.82	10
11	Social Service Workers	1,948	2,169	27,172	12.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,164	18,289	158,804	8.68	15
16	Dishwashers					16
17	Maintenance Workers	3,373	3,999	43,155	10.79	17
18	Housekeepers	9,484	10,045	70,658	7.03	18
19	Laundry	4,292	4,767	47,501	9.96	19
20	Administrator	1,900	2,080	62,483	30.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,140	8,845	140,444	15.88	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)	141,529	154,480	\$ 1,908,610 *	\$ 12.36	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	3,000		36
37	Medical Records Consultant	8,493		37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,240		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	3,378		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 18,111		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	106	\$ 4,251	50
51	Licensed Practical Nurses	0	0	51
52	Certified Nurse Assistants/Aides	0	0	52
53	TOTAL (lines 50 - 52)	106	\$ 4,251	53

Facility Name & ID Number Heritage Manor-Carlinville

# 0048850

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	
Karla Smith	admin		\$ 62,483	Workers' Compensation Insurance	\$ 52,709	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	32,079	Advertising: Employee Recruitment	5,117	
				FICA Taxes	146,009	Health Care Worker Background Check		
				Employee Health Insurance	188,888	(Indicate # of checks performed )	1,480	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Promotional Advertising	3,548	
					0	Public Relations	7,403	
				Employee Benefits -	13,927	Dues and Subscriptions	8,282	
				Employee Benefits	41,778	License and Fees	4,307	
						Central Office Allocation	6,580	
						Less: Public Relations Expense	(7,403)	
						Non-allowable advertising	(1,464)	
						Yellow page advertising	(3,548)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
			\$ 62,483		\$ 475,390		\$ 24,302	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								0
								888
							Seminar Expense	2,320
								(11,251)
								10,042
							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	Mgt		\$ 190,102					
McQuellen Consulting	Consulting		0					
			0					
			0					
			0					
Legal--Adjusted to Zero			275					
			0					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
			\$ 190,377					

\* Attach copy of IMRF notifications

\*\*See instructions.



**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 Carlinville 41509 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,130  
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. \$ 399
- (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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