

		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: 0048868

Facility Name: Heritage Manor-Chillicothe

Address: 1028 Hillcrest Drive Chillicothe 61523
 Number City Zip Code

County: Peoria

Telephone Number: (309) 274-2194 Fax # ()

HFS ID Number: 205412664001

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) () _____	Fax # () _____

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

Facility Name & ID Number Heritage Manor-Chillicothe

0048868 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	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,150</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>110</u>	TOTALS	<u>110</u>	<u>40,150</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>22,011</u>	<u>10,807</u>	<u>4,333</u>	<u>37,151</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,011</u>	<u>10,807</u>	<u>4,333</u>	<u>37,151</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.53%

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 4,333

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-Chillicothe # 0048868 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	197,295	17,024		214,319		214,319	5,967	220,286		1
2	Food Purchase		212,366		212,366		212,366	24	212,390		2
3	Housekeeping	93,659	16,131		109,790		109,790		109,790		3
4	Laundry	43,884	11,382		55,266		55,266		55,266		4
5	Heat and Other Utilities			106,979	106,979		106,979	1,701	108,680		5
6	Maintenance	60,257	53,617	41,875	155,749		155,749	13,486	169,235		6
7	Other (specify):*										7
8	TOTAL General Services	395,095	310,520	148,854	854,469		854,469	21,178	875,647		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000	2,136	14,136		9
10	Nursing and Medical Records	1,653,150	184,877	86,381	1,924,408		1,924,408		1,924,408		10
10a	Therapy		376,627	674,239	1,050,866	(401,965)	648,901	284,006	932,907		10a
11	Activities	62,053	5,686		67,739		67,739	1,553	69,292		11
12	Social Services	22,017		2,917	24,934		24,934		24,934		12
13	CNA Training	1,365	283		1,648		1,648	1,977	3,625		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,738,585	567,473	775,537	3,081,595	(401,965)	2,679,630	289,672	2,969,302		16
	C. General Administration										
17	Administrative	71,540			71,540		71,540	70,774	142,314		17
18	Directors Fees							6,297	6,297		18
19	Professional Services			250,940	250,940		250,940	(239,933)	11,007		19
20	Dues, Fees, Subscriptions & Promotions			148,484	148,484	(60,225)	88,259	(57,192)	31,067		20
21	Clerical & General Office Expenses	139,813	26,264	17,902	183,979		183,979	155,375	339,354		21
22	Employee Benefits & Payroll Taxes			455,096	455,096		455,096	42,552	497,648		22
23	Inservice Training & Education			1,558	1,558		1,558	441	1,999		23
24	Travel and Seminar			5,324	5,324		5,324	(3,325)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			80,441	80,441		80,441	6,273	86,714		26
27	Other (specify):*			54,063	54,063		54,063	(54,063)			27
28	TOTAL General Administration	211,353	26,264	1,013,808	1,251,425	(60,225)	1,191,200	(72,801)	1,118,399		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,345,033	904,257	1,938,199	5,187,489	(462,190)	4,725,299	238,049	4,963,348		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-Chillicothe #0048868 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			183,269	183,269		183,269	10,887	194,156		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			271,780	271,780		271,780	4,834	276,614		32
33	Real Estate Taxes			75,333	75,333		75,333		75,333		33
34	Rent-Facility & Grounds							6,648	6,648		34
35	Rent-Equipment & Vehicles			3,623	3,623		3,623	1,810	5,433		35
36	Other (specify):*										36
37	TOTAL Ownership			534,005	534,005		534,005	24,179	558,184		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					401,965	401,965		401,965		39
40	Barber and Beauty Shops			9,875	9,875		9,875		9,875		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					60,225	60,225		60,225		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			9,875	9,875	462,190	472,065		472,065		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,345,033	904,257	2,482,079	5,731,369		5,731,369	262,228	5,993,597		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-Chillicothe

0048868

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	(2,522)	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	(653)	20		17
18	Fines and Penalties				18
19	Entertainment	(13,553)	24		19
20	Contributions	(2,063)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,865)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(52,000)	27		24
25	Fund Raising, Advertising and Promotional	(63,241)	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)	\$ (140,897)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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)	403,125		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 403,125		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 262,228		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

Heritage Manor-Chillicothe

ID# 0048868

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	5
6	0	34	6
7			7
8			8
9	0	30	9
10		32	10
11			11
12			12
13	0	2	13
14		32	14
15	0	33	15
16		24	16
17	(653)	20	17
18			18
19		24	19
20	(2,063)	27	20
21			21
22	(6,865)	19	22
23			23
24	(52,000)	27	24
25	(63,241)	20	25
26			26
27			27
28			28
29	0	33	29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(124,822)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

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	5,967	0	0	0	0	0	0	0	0	5,967	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	1,701	0	0	0	0	0	0	0	0	1,701	5
6	Maintenance	0	0	13,486	0	0	0	0	0	0	0	0	13,486	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	21,178	0	0	0	0	0	0	0	0	21,178	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,136	0	0	0	0	0	0	0	0	2,136	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	284,006	0	0	0	0	0	0	0	0	0	284,006	10a
11	Activities	0	0	1,553	0	0	0	0	0	0	0	0	1,553	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,977	0	0	0	0	0	0	0	0	1,977	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	284,006	5,666	0	0	0	0	0	0	0	0	289,672	16
	C. General Administration													
17	Administrative	0	0	70,774	0	0	0	0	0	0	0	0	70,774	17
18	Directors Fees	0	0	6,297	0	0	0	0	0	0	0	0	6,297	18
19	Professional Services	(6,865)	(241,919)	8,851	0	0	0	0	0	0	0	0	(239,933)	19
20	Fees, Subscriptions & Promotions	(63,894)	0	6,702	0	0	0	0	0	0	0	0	(57,192)	20
21	Clerical & General Office Expenses	0	0	155,375	0	0	0	0	0	0	0	0	155,375	21
22	Employee Benefits & Payroll Taxes	0	0	42,552	0	0	0	0	0	0	0	0	42,552	22
23	Inservice Training & Education	0	0	441	0	0	0	0	0	0	0	0	441	23
24	Travel and Seminar	(13,553)	0	10,228	0	0	0	0	0	0	0	0	(3,325)	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	6,273	0	0	0	0	0	0	0	0	6,273	26
27	Other (specify):*	(54,063)	0	0	0	0	0	0	0	0	0	0	(54,063)	27
28	TOTAL General Administration	(138,375)	(241,919)	307,493	0	0	0	0	0	0	0	0	(72,801)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(138,375)	42,087	334,337	0	0	0	0	0	0	0	0	238,049	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

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	10,887	0	0	0	0	0	0	0	10,887	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,522)	0	0	7,356	0	0	0	0	0	0	0	4,834	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	6,648	0	0	0	0	0	0	0	6,648	34
35	Rent-Equipment & Vehicles	0	0	0	1,810	0	0	0	0	0	0	0	1,810	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,522)	0	0	26,701	0	24,179	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)	(140,897)	42,087	334,337	26,701	0	262,228	45						

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

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	241,919	Heritage Enterprises, Inc.			(241,919)	4
5	V							5
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		284,006	284,006	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 241,919			\$ 284,006	\$ * 42,087	14

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

Facility Name & ID Number Heritage Manor-Chillicothe# 0048868Report 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%	\$	5,967	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					1,701	19
20	V	6 Maintenance					13,486	20
21	V	7 Other					0	21
22	V	9 Medical Director					2,136	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					1,553	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,977	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					70,774	29
30	V	18 Directors Fees					6,297	30
31	V	19 Professional Services					8,851	31
32	V	20 Fees, Subscription, Promotions					6,702	32
33	V	21 Clerical & General Office Expenses					155,375	33
34	V	22 Employee Benefits & Payroll Taxes					42,552	34
35	V	23 Inservice Training & Education					441	35
36	V	24 Travel and Seminar					10,228	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					6,273	38
39	Total		\$			\$	0	\$ * 334,337 39

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

Facility Name & ID Number Heritage Manor-Chillicothe# 0048868Report 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					10,887	16
17	V	31	Amortization of Pre-Op & Org						17
18	V	32	Interest					7,356	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,648	20
21	V	35	Rent-Equipment & Vehicles					1,810	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	\$ * 26,701 39

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

Facility Name & ID Number Heritage Manor-Chillicothe # 0048868 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					\$ 6,297	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	\$ 6,297		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-Chillicothe

0048868

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
 City / State / Zip Code 3188
 Phone Number (Bloomington, IL 61701
 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	110	\$ 5,967	1
2	2	Food Purchase	Beds	2,624	25	577	0	110	24	2
3	3	Housekeeping	Beds	2,624	25	0	0	110	0	3
4	4	Laundry	Beds	2,624	25	0	0	110	0	4
5	5	Heat & Other Utilities	Beds	2,624	25	40,565	0	110	1,701	5
6	6	Maintenance	Beds	2,624	25	321,709	65,509	110	13,486	6
7	7	Other	Beds	2,624	25	0	0	110	0	7
8	9	Medical Director	Beds	2,624	25	50,960	0	110	2,136	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	56,488	110	0	9
10	11	Activities	Beds	2,624	25	37,038	36,931	110	1,553	10
11	12	Social Service	Beds	2,624	25	0	0	110	0	11
12	13	Nurse Aide Training	Beds	2,624	25	47,168	47,168	110	1,977	12
13	14	Program Transportation	Beds	2,624	25	0	0	110	0	13
14	15	Other	Beds	2,624	25	0	0	110	0	14
15	17	Administrative	Beds	2,624	25	1,688,288	1,688,288	110	70,774	15
16	18	Directors Fees	Beds	2,624	25	150,218	0	110	6,297	16
17	19	Professional Services	Beds	2,624	25	211,148	0	110	8,851	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	159,872	0	110	6,702	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,706,408	3,356,042	110	155,375	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	1,015,049	0	110	42,552	20
21	23	Inservice Training & Education	Beds	2,624	25	10,511	0	110	441	21
22	24	Travel and Seminar	Beds	2,624	25	243,988	0	110	10,228	22
23	25	Other Admin. Staff Transportatio	Beds	2,624	25	0	0	110	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,624	25	149,629	0	110	6,273	24
25	TOTALS					\$ 7,975,470	\$ 5,392,483		\$ 334,337	25

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	27	Other	Beds	2,624	25	\$	\$	110	\$	1
2	30	Depreciation	Beds	2,624	25	259,703		110	10,887	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25			110		3
4	32	Interest	Beds	2,624	25	175,477		110	7,356	4
5	33	Real Estate Taxes	Beds	2,624	25			110		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587		110	6,648	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166		110	1,810	7
8	36	Other	Beds	2,624	25			110		8
9	38	Medically Nec Transportation	Beds	2,624	25			110		9
10	39	Ancillary Service Centers	Beds	2,624	25			110		10
11	40	Barber and Beauty Shops	Beds	2,624	25			110		11
12	41	Coffee and Gift Shops	Beds	2,624	25			110		12
13	42	Other	Beds	2,624	25			110		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	\$		\$ 26,701	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			\$	\$ 43,127		\$ 253,467	1									
2	LsSalle National Bank		xx	Mortgage						3,145	2									
3											3									
4											4									
5											5									
Working Capital																				
6	LsSalle National Bank		xx	Working Capital						15,168	6									
7	LsSalle National Bank		xx								7									
8											8									
9	TOTAL Facility Related						\$	\$ 43,127		\$ 271,780	9									
B. Non-Facility Related*																				
10	Interest Income									(2,522)	10									
11	Allocated Corporate									7,356	11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ 4,834	14									
15	TOTALS (line 9+line14)						\$	\$ 43,127		\$ 276,614	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-Chillicothe COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0048868

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>05-29-376-016</u>	<u>nursing home</u>	\$ <u>72,293.00</u>	\$ <u>72,293.00</u>
2. <u>05-29-376-017</u>	<u></u>	\$ <u>1,078.00</u>	\$ <u>1,078.00</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>73,371.00</u>	\$ <u>73,371.00</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-Chillicothe

0048868 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,331 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>129,000</u>	1
2					2
3	TOTALS			\$ <u>129,000</u>	3

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

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	110				\$ 3,301,403	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Awning			1998	2,334						9
10	Heritage Sign			1998	1,860						10
11	Chiller Replacement			1998	54,444						11
12											12
13	Interior Remodel--Materials			1999	154,576						13
14				1999							14
15	Interior Remodel--Professional Fees			1999	24,247						15
16											16
17	Water Heater controls			2000	1,347						17
18	Water Heater			2000	57,254						18
19	Door Locks			2000	1,997						19
20	Heat / Cool Fan			2000	1,598						20
21	Fire Alarm System			2000	4,400						21
22	Alzheimer Unit -- Professional Fees			2000	25,115						22
23	Interior Remodel--Materials (see attached)			2000	93,951						23
24	Interior Remodel--Labor (see attached)			2000	23,130						24
25	Interior Remodel--Professional Fees (see attached)			2000	5,762						25
26											26
27	Water Softener			2001	4,246						27
28	Boiler			2001	29,350						28
29	Door Holders			2001	654						29
30	Alzheimer Unit -- Professional Fees			2001	4,660						30
31											31
32											32
33											33
34	C/O Allocation							10,887	10,887		34
35	Book Depreciation					143,953		143,953		1,132,426	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-Chillicothe

0048868

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	37	
38	Carpet	2002	2,373					38	
39	Compressor	2002	1,164					39	
40	Compressor	2002	7,234					40	
41	Windows	2002	1,722					41	
42								42	
43	Storage Tank	2003	737					43	
44	In-sink Aerator	2003	810					44	
45	Boiler	2003	16,393					45	
46	Carpet	2003	2,839					46	
47								47	
48	Smoke detectors	2004	2,285					48	
49	Dinning Room Waitress	2004	2,617					49	
50	Parking Lot Sealcoat	2004	4,926					50	
51	Boiler Pipe	2004	3,775					51	
52	Auto Trans Switch	2004	16,847					52	
53	Day Room	2004	1,778					53	
54								54	
55	Day Room	2005	8,753					55	
56	Boiler	2005	19,619					56	
57	Fire Alarm	2005	1,628					57	
58	Resident Room Carpet	2005	698					58	
59	Security System	2005	6,393					59	
60	Breaker Replacement	2005	1,980					60	
61	Condenser	2005	1,118					61	
62	Roof	2005	188,466					62	
63	Wiring	2005	820					63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)		\$ 4,087,303	\$ 143,953		\$ 154,840	\$ 10,887	\$ 1,132,426	70

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

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,087,303	\$ 143,953		\$ 154,840	\$ 10,887	\$ 1,132,426	1
2									2
3	Heat pump	2006	5,669						3
4	Boiler	2006	72,981						4
5	fire Alarm	2006	3,553						5
6	Roof	2006	1,300						6
7	Kitchen remodel	2006	4,623						7
8	Carpet	2006	1,139						8
9	Condensing Unit	2006	2,000						9
10	East Wing Dinning Room Remodel	2006	5,228						10
11									11
12	East Wing Remodel-- paint, floors	2007	25,094						12
13	Boiler	2007	970						13
14	Fire Alarm	2007	924						14
15	Generator	2007	1,675						15
16	Code Alert	2007	4,622						16
17	Fence	2007	3,089						17
18	Landscapping	2007	1,500						18
19	Parking Lot sealer	2007	5,000						19
20	Generator	2007	8,260						20
21	Heat pump	2007	21,969						21
22	Water Line	2007	1,296						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,258,195	\$ 143,953		\$ 154,840	\$ 10,887	\$ 1,132,426	34

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

Facility Name & ID Number Heritage Manor-Chillicothe # 0048868 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	\$ 536,443	\$ 39,316	\$ 39,316	\$		\$ 392,509	71
72	Current Year Purchases	15,352						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 551,795	\$ 39,316	\$ 39,316	\$		\$ 392,509	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)	\$ 4,938,990	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 183,269	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 194,156	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,887	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,524,935	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>240,900</u>	<u>5</u>		3
4	Additions							4
5								5
6								6
7	TOTAL				\$ <u>240,900</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.	/2008	\$	<u>240,900</u>
13.	/2009	\$	<u>240,900</u>
14.	/2010	\$	<u>240,900</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: \$ 5,433 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		283		283
3	Classroom Wages (a)		1,365		1,365
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,648	\$	\$ 1,648
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,648		

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	\$		\$ 210,528	\$		\$ 210,528	1
2	Licensed Speech and Language Development Therapist		hrs			95,768			95,768	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			340,559	2,046		342,605	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				374,581		374,581	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					27,384			27,384	13
14	TOTAL			\$		\$ 674,239	\$ 376,627		\$ 1,050,866	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-Chillicothe # 0048868 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 12,312	\$	1
2	Cash-Patient Deposits	8,692		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	652,326		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,841		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	344,786		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,022,957	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	129,000		13
14	Buildings, at Historical Cost	4,258,196		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	551,793		16
17	Accumulated Depreciation (book methods)	(1,524,935)		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):	10,443		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,424,497	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,447,454	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 204,057	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,692		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	179,405		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,555		31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,040		32
33	Accrued Interest Payable	23,065		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)	\$ 517,814	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,876,377		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)	\$ 3,876,377	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,394,191	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 53,263	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,447,454	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (355,119)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (355,119)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	458,382	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 408,382	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)	\$ 53,263	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Chillicothe# 0048868Report 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	\$ 5,892,419	1
2	Discounts and Allowances for all Levels	(2,887,655)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,004,764	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,547,894	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,547,894	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	2,702	12
13	Barber and Beauty Care	9,094	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,885	16
17	Sale of Drugs	626,390	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 641,071	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,522	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,522	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	other	(6,500)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (6,500)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,189,751	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	854,469	31
32	Health Care	3,081,595	32
33	General Administration	1,251,425	33
B. Capital Expense			
34	Ownership	534,005	34
C. Ancillary Expense			
35	Special Cost Centers	9,875	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,731,369	40
41	Income before Income Taxes (line 30 minus line 40)**	458,382	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 458,382	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-Chillicothe

0048868

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	1,559	1,808	\$ 46,709	\$ 25.83	1
2	Assistant Director of Nursing	190	200	6,194	30.97	2
3	Registered Nurses	5,415	5,900	135,729	23.00	3
4	Licensed Practical Nurses	17,438	18,706	425,813	22.76	4
5	CNAs & Orderlies	64,268	69,234	889,584	12.85	5
6	CNA Trainees	140	140	1,365	9.75	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,446	6,785	149,121	21.98	8
9	Activity Director					9
10	Activity Assistants	5,341	5,675	62,053	10.93	10
11	Social Service Workers	1,877	2,047	22,017	10.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,171	20,292	197,295	9.72	15
16	Dishwashers					16
17	Maintenance Workers	3,560	3,817	60,257	15.79	17
18	Housekeepers	9,935	10,380	93,659	9.02	18
19	Laundry	4,988	5,219	43,884	8.41	19
20	Administrator	1,900	2,080	71,540	34.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,619	8,408	139,813	16.63	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)	149,847	160,691	\$ 2,345,033 *	\$ 14.59	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		12,000		36
37	Medical Records Consultant		1,720		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,300		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,917		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,937		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	216	\$ 8,646		50
51	Licensed Practical Nurses	2,059	72,059		51
52	Certified Nurse Assistants/Aides	19	475		52
53	TOTAL (lines 50 - 52)	2,294	\$ 81,180		53

Facility Name & ID Number Heritage Manor-Chillicothe

0048868

Report Period Beginning: 01/01/07

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Marty Schlink	admin		\$ 71,540	Workers' Compensation Insurance	\$ 52,416	IDPH License Fee	\$ 0		
				Unemployment Compensation Insurance	29,393	Advertising: Employee Recruitment	11,033		
				FICA Taxes	179,395	Health Care Worker Background Check			
				Employee Health Insurance	165,476	(Indicate # of checks performed)	1,470		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Promotional Advertising	30,886		
					0	Public Relations	32,355		
				Employee Benefits -	28,416	Dues and Subscriptions	7,555		
				Employee Benefits	42,552	License and Fees	4,960		
						Central Office Allocation	6,702		
						Less: Public Relations Expense	(32,355)		
						Non-allowable advertising	(653)		
						Yellow page advertising	(30,886)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,540	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)			
				\$ 497,648		\$ 31,067			
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		
								174	
								1,293	
							Seminar Expense	3,857	
								(13,553)	
								10,228	
							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		\$ 241,919						
McQuellen Consulting	Consulting		2,156						
			0						
			0						
			0						
Legal--Adjusted to Zero			6,865						
			0						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 250,940						

* 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 Chillicothe 43885 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,225
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. \$ 2,704
- (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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