

		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:** 0048140

**Facility Name:** Heritage Manor-Colfax

**Address:** 402 South Harrison Box 379 Colfax 61728  
 Number City Zip Code

**County:** McLean

**Telephone Number:** ( 309 ) 697-6636 Fax # ( )

**HFS ID Number:** 203902003001

**Date of Initial License for Current Owners:** 07/2006

**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.

**Officer or Administrator of Provider**

(Signed) \_\_\_\_\_ 04/15/08  
 (Date)

(Type or Print Name) Craig Ater

(Title) Sr. VP & CFO

**Paid Preparer**

(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-Colfax

# 0048140 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	60	Skilled (SNF)	60	21,900	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	60	TOTALS	60	21,900	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	10,350	7,017	1,033	18,400	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,350	7,017	1,033	18,400	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.02%

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 07/2006

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 07/2006 NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 1,033

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-Colfax # 0048140 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	194,971	9,500		204,471		204,471	3,255	207,726		1
2	Food Purchase		95,137		95,137		95,137	13	95,150		2
3	Housekeeping	50,665	9,863		60,528		60,528		60,528		3
4	Laundry	38,211	5,686		43,897		43,897		43,897		4
5	Heat and Other Utilities			62,967	62,967		62,967	928	63,895		5
6	Maintenance	36,966	15,703	25,139	77,808		77,808	7,356	85,164		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>320,813</b>	<b>135,889</b>	<b>88,106</b>	<b>544,808</b>		<b>544,808</b>	<b>11,552</b>	<b>556,360</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600	1,165	10,765		9
10	Nursing and Medical Records	727,137	58,659	105,088	890,884		890,884		890,884		10
10a	Therapy		122,019	86,485	208,504	(125,475)	83,029	103,371	186,400		10a
11	Activities	20,354	732		21,086		21,086	847	21,933		11
12	Social Services	25,875		3,179	29,054		29,054		29,054		12
13	CNA Training	2,045	100		2,145		2,145	1,079	3,224		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>775,411</b>	<b>181,510</b>	<b>204,352</b>	<b>1,161,273</b>	<b>(125,475)</b>	<b>1,035,798</b>	<b>106,462</b>	<b>1,142,260</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	65,246			65,246		65,246	38,604	103,850		17
18	Directors Fees							3,435	3,435		18
19	Professional Services			153,516	153,516		153,516	(147,571)	5,945		19
20	Dues, Fees, Subscriptions & Promotions			60,992	60,992	(32,850)	28,142	(3,073)	25,069		20
21	Clerical & General Office Expenses	81,306	16,905	7,520	105,731		105,731	84,750	190,481		21
22	Employee Benefits & Payroll Taxes			259,549	259,549		259,549	23,210	282,759		22
23	Inservice Training & Education			1,759	1,759		1,759	240	1,999		23
24	Travel and Seminar			3,840	3,840		3,840	(1,841)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			42,216	42,216		42,216	3,421	45,637		26
27	Other (specify):*			525	525		525	(525)			27
28	<b>TOTAL General Administration</b>	<b>146,552</b>	<b>16,905</b>	<b>529,917</b>	<b>693,374</b>	<b>(32,850)</b>	<b>660,524</b>	<b>650</b>	<b>661,174</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,242,776</b>	<b>334,304</b>	<b>822,375</b>	<b>2,399,455</b>	<b>(158,325)</b>	<b>2,241,130</b>	<b>118,664</b>	<b>2,359,794</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-Colfax #0048140 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			67,273	67,273	67,273	5,938	73,211			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			72,763	72,763	72,763	1,602	74,365			32
33	Real Estate Taxes			16,469	16,469	16,469		16,469			33
34	Rent-Facility & Grounds						3,626	3,626			34
35	Rent-Equipment & Vehicles			5,384	5,384	5,384	987	6,371			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			161,889	161,889	161,889	12,153	174,042			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					125,475		125,475			39
40	Barber and Beauty Shops			8,795	8,795	8,795		8,795			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					32,850		32,850			42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			8,795	8,795	158,325		167,120			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,242,776	334,304	993,059	2,570,139	2,570,139	130,817	2,700,956			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-Colfax

# 0048140

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	(2,410)	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	323	20		17
18	Fines and Penalties				18
19	Entertainment	(7,420)	24		19
20	Contributions	(525)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(32,727)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(7,052)	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>	\$ (49,811)		\$	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)	180,628		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 180,628		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 130,817		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-Colfax

ID# 0048140

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		323	20
18			18
19			24
20		(525)	27
21			21
22		(32,727)	19
23			23
24		0	27
25		(7,052)	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>	(39,981)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Colfax

# 0048140

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	3,255	0	0	0	0	0	0	0	0	3,255	1
2	Food Purchase	0	0	13	0	0	0	0	0	0	0	0	13	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	928	0	0	0	0	0	0	0	0	928	5
6	Maintenance	0	0	7,356	0	0	0	0	0	0	0	0	7,356	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	11,552	0	0	0	0	0	0	0	0	11,552	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	1,165	0	0	0	0	0	0	0	0	1,165	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	103,371	0	0	0	0	0	0	0	0	0	103,371	10a
11	Activities	0	0	847	0	0	0	0	0	0	0	0	847	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,079	0	0	0	0	0	0	0	0	1,079	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	103,371	3,091	0	0	0	0	0	0	0	0	106,462	16
	<b>C. General Administration</b>													
17	Administrative	0	0	38,604	0	0	0	0	0	0	0	0	38,604	17
18	Directors Fees	0	0	3,435	0	0	0	0	0	0	0	0	3,435	18
19	Professional Services	(32,727)	(119,672)	4,828	0	0	0	0	0	0	0	0	(147,571)	19
20	Fees, Subscriptions & Promotions	(6,729)	0	3,656	0	0	0	0	0	0	0	0	(3,073)	20
21	Clerical & General Office Expenses	0	0	84,750	0	0	0	0	0	0	0	0	84,750	21
22	Employee Benefits & Payroll Taxes	0	0	23,210	0	0	0	0	0	0	0	0	23,210	22
23	Inservice Training & Education	0	0	240	0	0	0	0	0	0	0	0	240	23
24	Travel and Seminar	(7,420)	0	5,579	0	0	0	0	0	0	0	0	(1,841)	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	3,421	0	0	0	0	0	0	0	0	3,421	26
27	Other (specify):*	(525)	0	0	0	0	0	0	0	0	0	0	(525)	27
28	<b>TOTAL General Administration</b>	(47,401)	(119,672)	167,723	0	0	0	0	0	0	0	0	650	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(47,401)	(16,301)	182,366	0	0	0	0	0	0	0	0	118,664	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Colfax

# 0048140

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	5,938	0	0	0	0	0	0	0	5,938	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,410)	0	0	4,012	0	0	0	0	0	0	0	1,602	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	3,626	0	0	0	0	0	0	0	3,626	34
35	Rent-Equipment & Vehicles	0	0	0	987	0	0	0	0	0	0	0	987	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,410)</b>	<b>0</b>	<b>0</b>	<b>14,563</b>	<b>0</b>	<b>12,153</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>(49,811)</b>	<b>(16,301)</b>	<b>182,366</b>	<b>14,563</b>	<b>0</b>	<b>130,817</b>	<b>45</b>						

**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	119,672	Heritage Enterprises, Inc.			(119,672)	4
5	V							5
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		103,371	103,371	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 119,672			\$ 103,371	\$ * (16,301)	14

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

Facility Name & ID Number Heritage Manor-Colfax # 0048140 Report Period Beginning: 01/01/07 Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$	3,255	15
16	V	2 Food Purchase					13	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					928	19
20	V	6 Maintenance					7,356	20
21	V	7 Other					0	21
22	V	9 Medical Director					1,165	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					847	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,079	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					38,604	29
30	V	18 Directors Fees					3,435	30
31	V	19 Professional Services					4,828	31
32	V	20 Fees, Subscription, Promotions					3,656	32
33	V	21 Clerical & General Office Expenses					84,750	33
34	V	22 Employee Benefits & Payroll Taxes					23,210	34
35	V	23 Inservice Training & Education					240	35
36	V	24 Travel and Seminar					5,579	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					3,421	38
39	Total		\$			\$	0	\$ * 182,366 39

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

**VII. RELATED PARTIES (continued)**

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

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

1 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					5,938	16	
17	V	31	Amortization of Pre-Op & Org						17	
18	V	32	Interest					4,012	18	
19	V	33	Real Estate Taxes					0	19	
20	V	34	Rent-Facility & Grounds					3,626	20	
21	V	35	Rent-Equipment & Vehicles					987	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	\$ * 14,563	39

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

Facility Name & ID Number Heritage Manor-Colfax # 0048140 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					\$ 3,435	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	\$ 3,435		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-Colfax

# 0048140

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	60	\$ 3,255	1
2	2	Food Purchase	Beds	2,624	25	577	0	60	13	2
3	3	Housekeeping	Beds	2,624	25	0	0	60	0	3
4	4	Laundry	Beds	2,624	25	0	0	60	0	4
5	5	Heat & Other Utilities	Beds	2,624	25	40,565	0	60	928	5
6	6	Maintenance	Beds	2,624	25	321,709	65,509	60	7,356	6
7	7	Other	Beds	2,624	25	0	0	60	0	7
8	9	Medical Director	Beds	2,624	25	50,960	0	60	1,165	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	56,488	60	0	9
10	11	Activities	Beds	2,624	25	37,038	36,931	60	847	10
11	12	Social Service	Beds	2,624	25	0	0	60	0	11
12	13	Nurse Aide Training	Beds	2,624	25	47,168	47,168	60	1,079	12
13	14	Program Transportation	Beds	2,624	25	0	0	60	0	13
14	15	Other	Beds	2,624	25	0	0	60	0	14
15	17	Administrative	Beds	2,624	25	1,688,288	1,688,288	60	38,604	15
16	18	Directors Fees	Beds	2,624	25	150,218	0	60	3,435	16
17	19	Professional Services	Beds	2,624	25	211,148	0	60	4,828	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	159,872	0	60	3,656	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,706,408	3,356,042	60	84,750	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	1,015,049	0	60	23,210	20
21	23	Inservice Training & Education	Beds	2,624	25	10,511	0	60	240	21
22	24	Travel and Seminar	Beds	2,624	25	243,988	0	60	5,579	22
23	25	Other Admin. Staff Transportatio	Beds	2,624	25	0	0	60	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,624	25	149,629	0	60	3,421	24
25	TOTALS					\$ 7,975,470	\$ 5,392,483		\$ 182,366	25

Facility Name & ID Number Heritage Manor-Colfax

# 0048140

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	\$	60	\$	1
2	30	Depreciation	Beds	2,624	25	259,703	60	5,938	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		60		3
4	32	Interest	Beds	2,624	25	175,477	60	4,012	4
5	33	Real Estate Taxes	Beds	2,624	25		60		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587	60	3,626	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166	60	987	7
8	36	Other	Beds	2,624	25		60		8
9	38	Medically Nec Transportation	Beds	2,624	25		60		9
10	39	Ancillary Service Centers	Beds	2,624	25		60		10
11	40	Barber and Beauty Shops	Beds	2,624	25		60		11
12	41	Coffee and Gift Shops	Beds	2,624	25		60		12
13	42	Other	Beds	2,624	25		60		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	\$	\$ 14,563	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			\$	697,641		\$	59,036	1								
2	LsSalle National Bank		xx	Mortgage							5,448	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	LsSalle National Bank		xx	Working Capital							8,279	6								
7	LsSalle National Bank		xx									7								
8												8								
9	<b>TOTAL Facility Related</b>						\$	697,641		\$	72,763	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(2,410)	10								
11	Allocated Corporate										4,012	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$			\$	1,602	14								
15	<b>TOTALS (line 9+line14)</b>						\$	697,641		\$	74,365	15								

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

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

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

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 28,468	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 21,921	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (6,547)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 23,016	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 16,469	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	26,915	8
	2003	25,138	9
	2004	25,336	10
	2005	27,915	11
	2006	16,469	12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor-Colfax COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048140

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>17-03-478-012</u>	<u>nursing home</u>	\$ <u>21,921.00</u>	\$ <u>21,921.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>21,921.00</u>	\$ <u>21,921.00</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-Colfax

# 0048140 Report Period Beginning:

01/01/07 Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 13,016 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

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

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

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

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

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

none

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name & ID Number Heritage Manor-Colfax

# 0048140

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	60				\$ 840,000	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9		1995 Improvements		1995	38,109						9
10											10
11		Remodel---Interior Walls		1997	7,439						11
12		Addition		1997	5,229						12
13		Paint/Remodel Resident Room		1996	1,728						13
14		Kitchen A/C Unit		1996	3,125						14
15											15
16		Interior Remodel-Materials		1998	73,979						16
17		Roof Replacement		1998	67,876						17
18		Interior Remodel-Labor		1998	2,612						18
19											19
20		ALTA Survey		1999	2,862						20
21		Professional Fees		1999	1,900						21
22		Water Temp Control		1999	1,440						22
23											23
24		Interior Remodel -- Materials		2000	12,700						24
25		Interior Remodel -- Professional Fees		2000	698						25
26											26
27		Water Softener		2001	4,075						27
28		Generator		2001	1,827						28
29											29
30											30
31											31
32											32
33											33
34		C/O Allocation						5,938	5,938		34
35		Book Depreciation				53,007		53,007		506,643	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 &amp; ID Number Heritage Manor-Colfax

# 0048140

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	Seal Parking Lot	2002	\$ 750	\$		\$	\$	\$	37
38	A/C Unit	2002	2,528						38
39									39
40	Exit Doors	2003	2,892						40
41	Phone System	2003	5,958						41
42	A/C Unit	2003	1,941						42
43	Water Heater	2003	4,375						43
44	Friedrich Wallmaster	2003	1,294						44
45									45
46	A/C Unit	2004	8,164						46
47	Window Glazing	2004	1,578						47
48	Sidewalk	2004	3,479						48
49	Ansul System	2004	1,305						49
50	Seal Parking Lot	2004	820						50
51	Shower Room	2004	5,355						51
52									52
53	A/C Unit	2005	640						53
54	Business Office Remodel	2005	2,000						54
55	A/C Unit	2005	4,267						55
56	Kitchen Remodel -- Paint	2005	9,830						56
57	Window Glass Replacement	2005	1,469						57
58	Backflow preventor	2005	850						58
59	Sidewalk	2005	5,500						59
60									60
61	A/C Unit	2006	1,383						61
62	Nurse's station remodel	2006	7,127						62
63	Corridor Rehab	2006	5,784						63
64	Beauty shop paint	2006	519						64
65	Parking Lot	2006	55,795						65
66	Brick tuckpointing	2006	7,600						66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,208,802	\$ 53,007		\$ 58,945	\$ 5,938	\$ 506,643	70

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

Facility Name & ID Number Heritage Manor-Colfax

# 0048140

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		\$ 1,208,802	\$ 53,007		\$ 58,945	\$ 5,938	\$ 506,643	1
2									2
3	Overbed Lights	2007	8,759						3
4	HVAC	2007	7,663						4
5	PT Room Paint	2007	145						5
6	Door Alarm	2007	630						6
7	Door Alarm	2007	15,443						7
8	Water Heater	2007	5,992						8
9	Concrete Pad	2007	2,575						9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,250,009	\$ 53,007		\$ 58,945	\$ 5,938	\$ 506,643	34

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

Facility Name & ID Number Heritage Manor-Colfax # 0048140 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	\$ 291,691	\$ 14,266	\$ 14,266	\$		\$ 248,543	71
72	Current Year Purchases	22,267						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 313,958	\$ 14,266	\$ 14,266	\$		\$ 248,543	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)	\$ 1,603,967	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,273	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,211	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,938	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 755,186	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>131,400</u>	<u>5</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ <u>131,400</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>131,400</u>
13.	<u>/2009</u>	\$ <u>131,400</u>
14.	<u>/2010</u>	\$ <u>131,400</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: \$ 6,371 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		100		100
3	Classroom Wages (a)		2,045		2,045
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,145	\$	\$ 2,145
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,145		

**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.

Facility Name & ID Number Heritage Manor-Colfax# 0048140 Report Period Beginning:01/01/07 Ending:12/31/07

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 36,538	\$		\$ 36,538	1
2	Licensed Speech and Language Development Therapist		hrs			382			382	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			45,953	156		46,109	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				121,863		121,863	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					3,612			3,612	13
14	<b>TOTAL</b>			\$		\$ 86,485	\$ 122,019		\$ 208,504	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-Colfax# 0048140Report 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	\$ 545	\$	1
2	Cash-Patient Deposits	5,883		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	288,147		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,103		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(528,621)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (221,943)	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	1,250,007		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	313,958		16
17	Accumulated Depreciation (book methods)	(755,186)		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):	20,387		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 869,166	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 647,223	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 81,232	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,883		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	104,194		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,786		31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,016		32
33	Accrued Interest Payable	4,611		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>	\$ 233,722	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	697,641		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>	\$ 697,641	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 931,363	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (284,140)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 647,223	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (189,741)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (189,741)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(44,399)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (94,399)</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (284,140)</b>	24 *

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

Facility Name & ID Number Heritage Manor-Colfax# 0048140Report 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	\$ 2,463,052	1
2	Discounts and Allowances for all Levels	(455,824)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,007,228	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	293,761	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 293,761	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,917	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	211,424	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>	\$ 222,341	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,410	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,410	26
<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>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,525,740	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	544,808	31
32	Health Care	1,161,273	32
33	General Administration	693,374	33
<b>B. Capital Expense</b>			
34	Ownership	161,889	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	8,795	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>	\$ 2,570,139	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(44,399)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (44,399)	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-Colfax

# 0048140

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	1,737	1,960	\$ 47,396	\$ 24.18	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,023	4,394	99,291	22.60	3
4	Licensed Practical Nurses	5,983	6,421	139,308	21.70	4
5	CNAs & Orderlies	35,195	36,892	441,142	11.96	5
6	CNA Trainees	225	225	2,045	9.09	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	1,791	1,998	20,354	10.19	10
11	Social Service Workers	1,999	2,149	25,875	12.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,922	18,915	194,971	10.31	15
16	Dishwashers					16
17	Maintenance Workers	2,207	2,361	36,966	15.66	17
18	Housekeepers	5,444	5,835	50,665	8.68	18
19	Laundry	4,401	4,814	38,211	7.94	19
20	Administrator	1,900	2,080	65,246	31.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,607	4,218	81,306	19.28	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)	86,434	92,262	\$ 1,242,776 *	\$ 13.47	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	9,600		36
37	Medical Records Consultant	1,503		37
38	Nurse Consultant			38
39	Pharmacist Consultant	1,800		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	3,179		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 16,082		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,658	\$ 66,301	50
51	Licensed Practical Nurses	650	22,763	51
52	Certified Nurse Assistants/Aides	481	12,018	52
53	TOTAL (lines 50 - 52)	2,789	\$ 101,082	53





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES xx NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Heritage Manor colfax 41020 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 32,850  
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. \$ 6,596
- (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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