

		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: 0048116

Facility Name: Heritage Manor-Gibson City

Address: 620 E. 1st Street Gibson City 60936
 Number City Zip Code

County: Ford

Telephone Number: (217) 784-4257 Fax # ()

HFS ID Number: 20-39025/2001

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
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

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

Phone # (217) 782-1630

Facility Name & ID Number Heritage Manor-Gibson City# 0048116 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>75</u>	Skilled (SNF)	<u>75</u>	<u>27,375</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>75</u>	TOTALS	<u>75</u>	<u>27,375</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>10,975</u>	<u>8,642</u>	<u>1,057</u>	<u>20,674</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>10,975</u>	<u>8,642</u>	<u>1,057</u>	<u>20,674</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.52%

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 7/1/06 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 1,057Medicare 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-Gibson City # 0048116 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	181,448	5,786		187,234		187,234	4,068	191,302		1
2	Food Purchase		95,690		95,690		95,690	16	95,706		2
3	Housekeeping	57,609	9,544		67,153		67,153		67,153		3
4	Laundry	29,777	5,205		34,982		34,982		34,982		4
5	Heat and Other Utilities			58,553	58,553		58,553	1,159	59,712		5
6	Maintenance	53,498	20,580	23,602	97,680		97,680	9,195	106,875		6
7	Other (specify):*										7
8	TOTAL General Services	322,332	136,805	82,155	541,292		541,292	14,438	555,730		8
	B. Health Care and Programs										
9	Medical Director							1,457	1,457		9
10	Nursing and Medical Records	796,789	67,505	304,511	1,168,805		1,168,805		1,168,805		10
10a	Therapy		124,792	137,499	262,291	(139,252)	123,039	112,484	235,523		10a
11	Activities	48,371	351		48,722		48,722	1,059	49,781		11
12	Social Services	28,605		2,897	31,502		31,502		31,502		12
13	CNA Training	1,123	100		1,223		1,223	1,348	2,571		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	874,888	192,748	444,907	1,512,543	(139,252)	1,373,291	116,348	1,489,639		16
	C. General Administration										
17	Administrative	57,577			57,577		57,577	48,255	105,832		17
18	Directors Fees							4,294	4,294		18
19	Professional Services			139,621	139,621		139,621	(133,586)	6,035		19
20	Dues, Fees, Subscriptions & Promotions			61,567	61,567	(41,063)	20,504	(2,562)	17,942		20
21	Clerical & General Office Expenses	93,737	16,395	10,370	120,502		120,502	105,938	226,440		21
22	Employee Benefits & Payroll Taxes			293,992	293,992		293,992	29,012	323,004		22
23	Inservice Training & Education			1,168	1,168		1,168	300	1,468		23
24	Travel and Seminar			2,499	2,499		2,499	(500)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			54,157	54,157		54,157	4,277	58,434		26
27	Other (specify):*			820	820		820	(600)	220		27
28	TOTAL General Administration	151,314	16,395	564,194	731,903	(41,063)	690,840	54,828	745,668		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,348,534	345,948	1,091,256	2,785,738	(180,315)	2,605,423	185,614	2,791,037		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-Gibson City #0048116 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			97,294	97,294		97,294	7,423	104,717			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,231	83,231		83,231	4,290	87,521			32
33	Real Estate Taxes			39,581	39,581		39,581		39,581			33
34	Rent-Facility & Grounds							4,533	4,533			34
35	Rent-Equipment & Vehicles			5,289	5,289		5,289	1,234	6,523			35
36	Other (specify):*											36
37	TOTAL Ownership			225,395	225,395		225,395	17,480	242,875			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					139,252	139,252		139,252			39
40	Barber and Beauty Shops			2,506	2,506		2,506		2,506			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					41,063	41,063		41,063			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			2,506	2,506	180,315	182,821		182,821			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,348,534	345,948	1,319,157	3,013,639		3,013,639	203,094	3,216,733			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-Gibson City

0048116

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	(726)	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	(708)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,474)	24		19
20	Contributions	(600)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,132)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(6,424)	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)	\$ (25,064)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	228,158		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 228,158		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 203,094		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Gibson City

ID# 0048116

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		(708)	20
18			18
19			24
20		(600)	27
21			21
22		(9,132)	19
23			23
24		0	27
25		(6,424)	20
26			26
27			27
28			28
29		0	33
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(16,864)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Gibson City

0048116

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,068	0	0	0	0	0	0	0	0	4,068	1
2	Food Purchase	0	0	16	0	0	0	0	0	0	0	0	16	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,159	0	0	0	0	0	0	0	0	1,159	5
6	Maintenance	0	0	9,195	0	0	0	0	0	0	0	0	9,195	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	14,438	0	0	0	0	0	0	0	0	14,438	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,457	0	0	0	0	0	0	0	0	1,457	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	112,484	0	0	0	0	0	0	0	0	0	112,484	10a
11	Activities	0	0	1,059	0	0	0	0	0	0	0	0	1,059	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,348	0	0	0	0	0	0	0	0	1,348	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	112,484	3,864	0	0	0	0	0	0	0	0	116,348	16
	C. General Administration													
17	Administrative	0	0	48,255	0	0	0	0	0	0	0	0	48,255	17
18	Directors Fees	0	0	4,294	0	0	0	0	0	0	0	0	4,294	18
19	Professional Services	(9,132)	(130,489)	6,035	0	0	0	0	0	0	0	0	(133,586)	19
20	Fees, Subscriptions & Promotions	(7,132)	0	4,570	0	0	0	0	0	0	0	0	(2,562)	20
21	Clerical & General Office Expenses	0	0	105,938	0	0	0	0	0	0	0	0	105,938	21
22	Employee Benefits & Payroll Taxes	0	0	29,012	0	0	0	0	0	0	0	0	29,012	22
23	Inservice Training & Education	0	0	300	0	0	0	0	0	0	0	0	300	23
24	Travel and Seminar	(7,474)	0	6,974	0	0	0	0	0	0	0	0	(500)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,277	0	0	0	0	0	0	0	0	4,277	26
27	Other (specify):*	(600)	0	0	0	0	0	0	0	0	0	0	(600)	27
28	TOTAL General Administration	(24,338)	(130,489)	209,655	0	0	0	0	0	0	0	0	54,828	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,338)	(18,005)	227,957	0	0	0	0	0	0	0	0	185,614	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Gibson City

0048116

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	7,423	0	0	0	0	0	0	0	7,423	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(726)	0	0	5,016	0	0	0	0	0	0	0	4,290	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	4,533	0	0	0	0	0	0	0	4,533	34
35	Rent-Equipment & Vehicles	0	0	0	1,234	0	0	0	0	0	0	0	1,234	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(726)	0	0	18,206	0	17,480	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)	(25,064)	(18,005)	227,957	18,206	0	203,094	45						

Facility Name & ID Number Heritage Manor-Gibson City

0048116

Report Period Beginning:

01/01/07

Ending:

12/31/07

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization						2
3	V							3
4	V	19 Adjustment for Related Organization	130,489	Heritage Enterprises, Inc.			(130,489)	4
5	V							5
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		112,484	112,484	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 130,489			\$ 112,484	\$ * (18,005)	14

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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%	\$	4,068	15
16	V	2 Food Purchase					16	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,159	19
20	V	6 Maintenance					9,195	20
21	V	7 Other					0	21
22	V	9 Medical Director					1,457	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					1,059	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,348	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					48,255	29
30	V	18 Directors Fees					4,294	30
31	V	19 Professional Services					6,035	31
32	V	20 Fees, Subscription, Promotions					4,570	32
33	V	21 Clerical & General Office Expenses					105,938	33
34	V	22 Employee Benefits & Payroll Taxes					29,012	34
35	V	23 Inservice Training & Education					300	35
36	V	24 Travel and Seminar					6,974	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					4,277	38
39	Total		\$			\$	0	\$ * 227,957 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	27 Other	\$		100.00%	\$	0	15	
16	V	30 Depreciation					7,423	16	
17	V	31 Amortization of Pre-Op & Org						17	
18	V	32 Interest					5,016	18	
19	V	33 Real Estate Taxes					0	19	
20	V	34 Rent-Facility & Grounds					4,533	20	
21	V	35 Rent-Equipment & Vehicles					1,234	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	\$ * 18,206	39

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises, Inc.	Member		100.00					\$ 4,294	line 18	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,294		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-Gibson City

0048116

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	75	\$ 4,068	1
2	2	Food Purchase	Beds	2,624	25	577	0	75	16	2
3	3	Housekeeping	Beds	2,624	25	0	0	75	0	3
4	4	Laundry	Beds	2,624	25	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,624	25	40,565	0	75	1,159	5
6	6	Maintenance	Beds	2,624	25	321,709	65,509	75	9,195	6
7	7	Other	Beds	2,624	25	0	0	75	0	7
8	9	Medical Director	Beds	2,624	25	50,960	0	75	1,457	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	56,488	75	0	9
10	11	Activities	Beds	2,624	25	37,038	36,931	75	1,059	10
11	12	Social Service	Beds	2,624	25	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,624	25	47,168	47,168	75	1,348	12
13	14	Program Transportation	Beds	2,624	25	0	0	75	0	13
14	15	Other	Beds	2,624	25	0	0	75	0	14
15	17	Administrative	Beds	2,624	25	1,688,288	1,688,288	75	48,255	15
16	18	Directors Fees	Beds	2,624	25	150,218	0	75	4,294	16
17	19	Professional Services	Beds	2,624	25	211,148	0	75	6,035	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	159,872	0	75	4,570	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,706,408	3,356,042	75	105,938	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	1,015,049	0	75	29,012	20
21	23	Inservice Training & Education	Beds	2,624	25	10,511	0	75	300	21
22	24	Travel and Seminar	Beds	2,624	25	243,988	0	75	6,974	22
23	25	Other Admin. Staff Transportatio	Beds	2,624	25	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,624	25	149,629	0	75	4,277	24
25	TOTALS					\$ 7,975,470	\$ 5,392,483		\$ 227,957	25

Facility Name & ID Number Heritage Manor-Gibson City

0048116

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	\$	75	\$	1
2	30	Depreciation	Beds	2,624	25	259,703	75	7,423	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		75		3
4	32	Interest	Beds	2,624	25	175,477	75	5,016	4
5	33	Real Estate Taxes	Beds	2,624	25		75		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587	75	4,533	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166	75	1,234	7
8	36	Other	Beds	2,624	25		75		8
9	38	Medically Nec Transportation	Beds	2,624	25		75		9
10	39	Ancillary Service Centers	Beds	2,624	25		75		10
11	40	Barber and Beauty Shops	Beds	2,624	25		75		11
12	41	Coffee and Gift Shops	Beds	2,624	25		75		12
13	42	Other	Beds	2,624	25		75		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	\$	\$ 18,206	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			\$	801,351		\$	67,243	1								
2	LsSalle National Bank		xx	Mortgage							5,670	2								
3												3								
4												4								
5												5								
Working Capital																				
6	LsSalle National Bank		xx	Working Capital							10,318	6								
7	LsSalle National Bank		xx									7								
8												8								
9	TOTAL Facility Related						\$	801,351		\$	83,231	9								
B. Non-Facility Related*																				
10	Interest Income										(726)	10								
11	Allocated Corporate										5,016	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$			\$	4,290	14								
15	TOTALS (line 9+line14)						\$	801,351		\$	87,521	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

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	40,705	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.)			\$	39,164	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,541)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	41,122	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	39,581	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2002	<u>39,808</u>	<u>8</u>			
2003	<u>40,917</u>	<u>9</u>			
2004	<u>36,943</u>	<u>10</u>			
2005	<u>42,119</u>	<u>11</u>			
2006	<u>39,581</u>	<u>12</u>			
			FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$		13	
14	PLUS APPEAL COST FROM LINE 5	\$		14	
15	LESS REFUND FROM LINE 6	\$		15	
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16	

NOTES:

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

IMPORTANT NOTICE

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

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

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

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

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Gibson City COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0048116

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>09-11-11-482-001</u>	<u>Nursing Home</u>	\$ <u>39,022.00</u>	\$ <u>39,022.00</u>
2. <u>09-11-11-479-017</u>	<u></u>	\$ <u>142.00</u>	\$ <u>142.00</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>39,164.00</u>	\$ <u>39,164.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,129 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				\$ 20,000	1
2					2
3	TOTALS			\$ 20,000	3

Facility Name & ID Number Heritage Manor-Gibson City

0048116

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	75				\$ 815,350	\$		\$	\$	\$	4
5					912,769						5
6											6
7											7
8											8
	Improvement Type**										
9	1981 Improvements			1981	41,753						9
10	1982 Improvements			1982	6,437						10
11	1983 Improvements			1983	240						11
12	1984 Improvements			1984	873						12
13	1985 Improvements			1985	7,530						13
14	1986 Improvements			1986	20,979						14
15	1987 Improvements			1987	2,222						15
16	1988 Improvements			1988	2,452						16
17	1989 Improvements			1989	28,639						17
18	1990 Improvements			1990	99,326						18
19	1991 Improvements			1991	36,637						19
20	1993 Improvements			1993	40,838						20
21	1994 Improvements			1994	66,399						21
22	1995 Improvements			1995	1,060						22
23	WINDOW REPLACEMENTS			1996	25,247						23
24	WATER HEATER			1996	1,639						24
25	RESIDENT ROOM REMODEL/PAINTING			1996	7,584						25
26	Parking Lot			1998	12,299						26
27											27
28	Smoke Dampers			1999	5,256						28
29	Water Heater			1999	1,971						29
30	Garbage Disposal			1999	1,693						30
31	Heat/Cool compressor			1999	3,277						31
32	Smoke Dampers			2000	1,295						32
33											33
34	C/O Allocation							7,423	7,423		34
35	Book Depreciation					69,333		69,333		958,283	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-Gibson City# 0048116

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	Temperature Control Unit	2001	\$ 1,700	\$		\$	\$	\$	37
38	AC Replacement	2001	4,400						38
39	Smoke Detection System								39
40									40
41	Smoke Detection System	2002	1,775						41
42	Landscaping	2002	1,425						42
43	Fire Supression	2002	4,458						43
44	Water Heater	2002	2,396						44
45	Keypad Perimeter	2002	941						45
46	Sealcoat Parking Lot	2002	1,371						46
47	Garbage Disposal	2002	1,520						47
48	Hot Water Tank	2002	3,168						48
49	Rehab Hallway--Wallpaper/Paint	2002	14,442						49
50									50
51	Exterior Doors	2003	2,195						51
52	Roof Replacement	2003	28,555						52
53	Security Door	2003	1,116						53
54	Water Heater	2003	1,999						54
55	Water Tank	2003	1,836						55
56									56
57	HVAC unit	2004	5,247						57
58	Grease Trap	2004	1,903						58
59	Quarry Tile	2004	3,165						59
60	Parking Lot Sealcoat	2004	1,579						60
61	HVAC unit	2004	1,000						61
62	Sprinkler Leak	2004	1,854						62
63	Hot Water Boiler	2004	2,133						63
64	Corridor Remodel Material and Labor	2004	20,242						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,254,185	\$ 69,333		\$ 76,756	\$ 7,423	\$ 958,283	70

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

Facility Name & ID Number Heritage Manor-Gibson City

0048116

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,254,185	\$ 69,333		\$ 76,756	\$ 7,423	\$ 958,283	1
2									2
3	Oxygen Room	2005	2,005						3
4	Heat/Cool Unit	2005	17,228						4
5									5
6	Heat/Cool Units	2006	25,182						6
7	Door	2006	2,887						7
8	Heater	2006	1,078						8
9	Sidewalk	2006	3,500						9
10	Boiler	2006	1,427						10
11	Remodel TLC Unit --carpet, paint,	2006	27,516						11
12	Parking Lot sealer	2006	1,699						12
13	Drapes	2006	1,172						13
14									14
15	dishwasher motor	2007	1,591						15
16	Remodel TLC Unit --carpet, paint,	2007	2,996						16
17	Water Heater	2007	2,907						17
18	Grease Trap	2007	1,884						18
19	Water Softener	2007	12,285						19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,359,542	\$ 69,333		\$ 76,756	\$ 7,423	\$ 958,283	34

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

Facility Name & ID Number Heritage Manor-Gibson City

0048116

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 2,359,542	\$ 69,333		\$ 76,756	\$ 7,423	\$ 958,283		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									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)	\$ 2,359,542	\$ 69,333		\$ 76,756	\$ 7,423	\$ 958,283		34

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

Facility Name & ID Number Heritage Manor-Gibson City # 0048116 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	\$ 421,408	\$ 27,961	\$ 27,961	\$		\$ 384,778	71
72	Current Year Purchases	15,037						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 436,445	\$ 27,961	\$ 27,961	\$		\$ 384,778	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,815,987	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,294	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 104,717	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,423	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,343,061	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:	75	07/2006	\$ 164,260	5		3
4	Additions						4
5							5
6							6
7	TOTAL	75		\$ 164,260			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	\$	164,260
13.	/2009	\$	164,260
14.	/2010	\$	164,260

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: \$ 6,523 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		100		100
3	Classroom Wages (a)		1,123		1,123
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,223	\$	\$ 1,223
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,223		

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Heritage Manor-Gibson City# 0048116 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	\$		\$ 63,096	\$		\$ 63,096	1
2	Licensed Speech and Language Development Therapist		hrs			2,667			2,667	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			57,205	71		57,276	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				124,721		124,721	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					14,531			14,531	13
14	TOTAL			\$		\$ 137,499	\$ 124,792		\$ 262,291	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-Gibson City # 0048116 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	\$ 8,387	\$	1
2	Cash-Patient Deposits	4,112		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	285,984		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,952		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(981,315)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (668,880)	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000		13
14	Buildings, at Historical Cost	2,183,126		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	485,012		16
17	Accumulated Depreciation (book methods)	(1,343,061)		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):	20,984		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,366,061	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 697,181	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 131,501	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,112		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	128,275		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,603		31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,122		32
33	Accrued Interest Payable			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)	\$ 306,613	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	801,351		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)	\$ 801,351	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,107,964	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (410,783)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 697,181	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (180,066)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (180,066)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(180,717)	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)	\$ (230,717)	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)	\$ (410,783)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Gibson City# 0048116Report 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	\$ 2,790,444	1
2	Discounts and Allowances for all Levels	(625,182)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,165,262	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	448,713	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 448,713	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	1,643	12
13	Barber and Beauty Care	5,485	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	212,003	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)	\$ 219,131	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	726	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 726	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	other	(910)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (910)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,832,922	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	541,292	31
32	Health Care	1,512,543	32
33	General Administration	731,903	33
B. Capital Expense			
34	Ownership	225,395	34
C. Ancillary Expense			
35	Special Cost Centers	2,506	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)*	\$ 3,013,639	40
41	Income before Income Taxes (line 30 minus line 40)**	(180,717)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (180,717)	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-Gibson City

0048116

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	2,002	2,090	\$ 56,198	\$ 26.89	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	3,779	3,939	106,322	26.99	3
4	Licensed Practical Nurses	6,618	7,013	168,286	24.00	4
5	CNAs & Orderlies	33,825	36,048	403,862	11.20	5
6	CNA Trainees	125	125	1,123	8.98	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,539	4,028	62,121	15.42	8
9	Activity Director					9
10	Activity Assistants	3,751	4,150	48,371	11.66	10
11	Social Service Workers	1,935	2,119	28,605	13.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,722	16,403	181,448	11.06	15
16	Dishwashers					16
17	Maintenance Workers	2,812	3,298	53,498	16.22	17
18	Housekeepers	6,741	7,820	57,609	7.37	18
19	Laundry	1,839	2,011	29,777	14.81	19
20	Administrator	1,900	2,080	57,577	27.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,982	6,681	93,737	14.03	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)	89,570	97,805	\$ 1,348,534 *	\$ 13.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		0		36
37	Medical Records Consultant		1,350		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,250		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		2,897		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 6,497		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,196	\$ 127,832		50
51	Licensed Practical Nurses	2,371	82,991		51
52	Certified Nurse Assistants/Aides	3,589	89,727		52
53	TOTAL (lines 50 - 52)	9,156	\$ 300,550		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 Gibson City 38315 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 41,063
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. \$ 8,351
- (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? no**
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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