

Facility Name & ID Number Heritage Manor-Normal

0048082 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	164	Skilled (SNF)	164	59,860	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	164	TOTALS	164	59,860	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	27,202	21,129	3,758	52,089	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,202	21,129	3,758	52,089	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.02%

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 3,758

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-Normal # 0048082 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	420,810	25,227		446,037		446,037	8,896	454,933			1
2	Food Purchase		257,066		257,066		257,066	36	257,102			2
3	Housekeeping	179,865	46,405		226,270		226,270		226,270			3
4	Laundry	115,143	22,601		137,744		137,744		137,744			4
5	Heat and Other Utilities			157,370	157,370		157,370	2,535	159,905			5
6	Maintenance	149,731	63,054	65,421	278,206		278,206	20,107	298,313			6
7	Other (specify):*											7
8	TOTAL General Services	865,549	414,353	222,791	1,502,693		1,502,693	31,574	1,534,267			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600	3,185	12,785			9
10	Nursing and Medical Records	2,537,460	146,996	92,764	2,777,220		2,777,220		2,777,220			10
10a	Therapy		405,431	534,402	939,833	(419,354)	520,479	242,004	762,483			10a
11	Activities	133,323	3,118		136,441		136,441	2,315	138,756			11
12	Social Services	42,273		3,918	46,191		46,191		46,191			12
13	CNA Training	21,927	2,405		24,332		24,332	2,948	27,280			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,734,983	557,950	640,684	3,933,617	(419,354)	3,514,263	250,452	3,764,715			16
	C. General Administration											
17	Administrative	76,176			76,176		76,176	105,518	181,694			17
18	Directors Fees							9,389	9,389			18
19	Professional Services			385,965	385,965		385,965	(372,768)	13,197			19
20	Dues, Fees, Subscriptions & Promotions			141,538	141,538	(89,790)	51,748	(7,637)	44,111			20
21	Clerical & General Office Expenses	243,407	25,172	14,670	283,249		283,249	231,651	514,900			21
22	Employee Benefits & Payroll Taxes			756,814	756,814		756,814	63,441	820,255			22
23	Inservice Training & Education			1,342	1,342		1,342	657	1,999			23
24	Travel and Seminar			2,906	2,906		2,906	(907)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			114,963	114,963		114,963	9,352	124,315			26
27	Other (specify):*			12,501	12,501		12,501	(12,000)	501			27
28	TOTAL General Administration	319,583	25,172	1,430,699	1,775,454	(89,790)	1,685,664	26,696	1,712,360			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,920,115	997,475	2,294,174	7,211,764	(509,144)	6,702,620	308,722	7,011,342			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-Normal #0048082 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			287,001	287,001	287,001	16,231	303,232			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			406,095	406,095	406,095	9,541	415,636			32
33	Real Estate Taxes			102,125	102,125	102,125		102,125			33
34	Rent-Facility & Grounds						9,912	9,912			34
35	Rent-Equipment & Vehicles			3,509	3,509	3,509	2,698	6,207			35
36	Other (specify):*										36
37	TOTAL Ownership			798,730	798,730	798,730	38,382	837,112			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					419,354		419,354			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee					89,790		89,790			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers					509,144		509,144			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,920,115	997,475	3,092,904	8,010,494	8,010,494	347,104	8,357,598			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-Normal

0048082

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	(1,426)	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	(787)	20		17
18	Fines and Penalties				18
19	Entertainment	(16,156)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,411)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(16,842)	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)	\$ (51,622)		\$	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)	398,726		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 398,726		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 347,104		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-Normal

ID# 0048082

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		(787)	20
18			18
19			24
20		0	27
21			21
22		(4,411)	19
23			23
24		(12,000)	27
25		(16,842)	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	(34,040)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Normal

0048082

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	8,896	0	0	0	0	0	0	0	0	8,896	1
2	Food Purchase	0	0	36	0	0	0	0	0	0	0	0	36	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	2,535	0	0	0	0	0	0	0	0	2,535	5
6	Maintenance	0	0	20,107	0	0	0	0	0	0	0	0	20,107	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	31,574	0	0	0	0	0	0	0	0	31,574	8
	B. Health Care and Programs													
9	Medical Director	0	0	3,185	0	0	0	0	0	0	0	0	3,185	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	242,004	0	0	0	0	0	0	0	0	0	242,004	10a
11	Activities	0	0	2,315	0	0	0	0	0	0	0	0	2,315	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	2,948	0	0	0	0	0	0	0	0	2,948	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	242,004	8,448	0	0	0	0	0	0	0	0	250,452	16
	C. General Administration													
17	Administrative	0	0	105,518	0	0	0	0	0	0	0	0	105,518	17
18	Directors Fees	0	0	9,389	0	0	0	0	0	0	0	0	9,389	18
19	Professional Services	(4,411)	(381,554)	13,197	0	0	0	0	0	0	0	0	(372,768)	19
20	Fees, Subscriptions & Promotions	(17,629)	0	9,992	0	0	0	0	0	0	0	0	(7,637)	20
21	Clerical & General Office Expenses	0	0	231,651	0	0	0	0	0	0	0	0	231,651	21
22	Employee Benefits & Payroll Taxes	0	0	63,441	0	0	0	0	0	0	0	0	63,441	22
23	Inservice Training & Education	0	0	657	0	0	0	0	0	0	0	0	657	23
24	Travel and Seminar	(16,156)	0	15,249	0	0	0	0	0	0	0	0	(907)	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	9,352	0	0	0	0	0	0	0	0	9,352	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	TOTAL General Administration	(50,196)	(381,554)	458,446	0	0	0	0	0	0	0	0	26,696	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(50,196)	(139,550)	498,468	0	0	0	0	0	0	0	0	308,722	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Normal

0048082

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	16,231	0	0	0	0	0	0	0	16,231	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,426)	0	0	10,967	0	0	0	0	0	0	0	9,541	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	9,912	0	0	0	0	0	0	0	9,912	34
35	Rent-Equipment & Vehicles	0	0	0	2,698	0	0	0	0	0	0	0	2,698	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,426)	0	0	39,808	0	38,382	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)	(51,622)	(139,550)	498,468	39,808	0	347,104	45						

Facility Name & ID Number Heritage Manor-Normal

0048082

Report Period Beginning:

01/01/07

Ending:

12/31/07

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	\$
2	V	10a Adjustment for Related Organization					
3	V						
4	V	19 Adjustment for Related Organization	381,554	Heritage Enterprises, Inc.			(381,554)
5	V						
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		242,004	242,004
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 381,554			\$ 242,004	\$ * (139,550)

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

Facility Name & ID Number Heritage Manor-Normal# 0048082Report Period Beginning: 01/01/07Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$	8,896	15
16	V	2 Food Purchase					36	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					2,535	19
20	V	6 Maintenance					20,107	20
21	V	7 Other					0	21
22	V	9 Medical Director					3,185	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					2,315	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					2,948	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					105,518	29
30	V	18 Directors Fees					9,389	30
31	V	19 Professional Services					13,197	31
32	V	20 Fees, Subscription, Promotions					9,992	32
33	V	21 Clerical & General Office Expenses					231,651	33
34	V	22 Employee Benefits & Payroll Taxes					63,441	34
35	V	23 Inservice Training & Education					657	35
36	V	24 Travel and Seminar					15,249	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					9,352	38
39	Total		\$			\$	0	\$ * 498,468 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					16,231	16
17	V	31 Amortization of Pre-Op & Org						17
18	V	32 Interest					10,967	18
19	V	33 Real Estate Taxes					0	19
20	V	34 Rent-Facility & Grounds					9,912	20
21	V	35 Rent-Equipment & Vehicles					2,698	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	\$ * 39,808 39

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

Facility Name & ID Number Heritage Manor-Normal # 0048082 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					\$ 9,389	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	\$ 9,389		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-Normal

0048082

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	164	\$ 8,896	1
2	2	Food Purchase	Beds	2,624	25	577	0	164	36	2
3	3	Housekeeping	Beds	2,624	25	0	0	164	0	3
4	4	Laundry	Beds	2,624	25	0	0	164	0	4
5	5	Heat & Other Utilities	Beds	2,624	25	40,565	0	164	2,535	5
6	6	Maintenance	Beds	2,624	25	321,709	65,509	164	20,107	6
7	7	Other	Beds	2,624	25	0	0	164	0	7
8	9	Medical Director	Beds	2,624	25	50,960	0	164	3,185	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	56,488	164	0	9
10	11	Activities	Beds	2,624	25	37,038	36,931	164	2,315	10
11	12	Social Service	Beds	2,624	25	0	0	164	0	11
12	13	Nurse Aide Training	Beds	2,624	25	47,168	47,168	164	2,948	12
13	14	Program Transportation	Beds	2,624	25	0	0	164	0	13
14	15	Other	Beds	2,624	25	0	0	164	0	14
15	17	Administrative	Beds	2,624	25	1,688,288	1,688,288	164	105,518	15
16	18	Directors Fees	Beds	2,624	25	150,218	0	164	9,389	16
17	19	Professional Services	Beds	2,624	25	211,148	0	164	13,197	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	159,872	0	164	9,992	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,706,408	3,356,042	164	231,651	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	1,015,049	0	164	63,441	20
21	23	Inservice Training & Education	Beds	2,624	25	10,511	0	164	657	21
22	24	Travel and Seminar	Beds	2,624	25	243,988	0	164	15,249	22
23	25	Other Admin. Staff Transportatio	Beds	2,624	25	0	0	164	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,624	25	149,629	0	164	9,352	24
25	TOTALS					\$ 7,975,470	\$ 5,392,483		\$ 498,468	25

Facility Name & ID Number Heritage Manor-Normal

0048082

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	\$	164	\$	1
2	30	Depreciation	Beds	2,624	25	259,703	164	16,231	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		164		3
4	32	Interest	Beds	2,624	25	175,477	164	10,967	4
5	33	Real Estate Taxes	Beds	2,624	25		164		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587	164	9,912	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166	164	2,698	7
8	36	Other	Beds	2,624	25		164		8
9	38	Medically Nec Transportation	Beds	2,624	25		164		9
10	39	Ancillary Service Centers	Beds	2,624	25		164		10
11	40	Barber and Beauty Shops	Beds	2,624	25		164		11
12	41	Coffee and Gift Shops	Beds	2,624	25		164		12
13	42	Other	Beds	2,624	25		164		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	\$		\$ 39,808	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			\$	\$ 5,322,282		\$ 376,521	1									
2	LsSalle National Bank		xx	Mortgage						6,960	2									
3											3									
4											4									
5											5									
Working Capital																				
6	LsSalle National Bank		xx	Working Capital						22,614	6									
7	LsSalle National Bank		xx								7									
8											8									
9	TOTAL Facility Related						\$	\$ 5,322,282		\$ 406,095	9									
B. Non-Facility Related*																				
10	Interest Income									(1,426)	10									
11	Allocated Corporate									10,967	11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ 9,541	14									
15	TOTALS (line 9+line14)						\$	\$ 5,322,282		\$ 415,636	15									

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

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

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

IMPORTANT NOTICE

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

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

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

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

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Normal COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048082

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>14-29-227-016</u>	<u>nursing home</u>	\$ <u>127,294.00</u>	\$ <u>67,906.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>127,294.00</u>	\$ <u>67,906.00</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-Normal

0048082 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,164 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>60,687</u>	1
2					2
3	TOTALS			\$ <u>60,687</u>	3

Facility Name & ID Number Heritage Manor-Normal

0048082

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	164				\$ 1,860,193	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	1979 Improvements			1979	66,917						9
10	1980 Improvements			1980	48,089						10
11	1981 Improvements			1981	17,747						11
12	1982 Improvements			1982	18,009						12
13	1983 Improvements			1983	19,892						13
14	1984 Improvements			1984	25,484						14
15	1985 Improvements			1985	531,851						15
16	1986 Improvements			1986	82,460						16
17	1987 Improvements			1987	17,447						17
18	1988 Improvements			1988	133,532						18
19	1989 Improvements			1989	39,555						19
20	1990 Improvements			1990	18,557						20
21	1991 Improvements			1991	5,776						21
22	1992 Improvements			1992	8,016						22
23	1993 Improvements			1993	188,048						23
24	1994 Improvements			1994	187,325						24
25	1995 Improvements			1995	10,664						25
26	A/C Basement Laundry			1996	6,741						26
27	Asphalt Repair			1996	21,401						27
28	Remodel/Painting			1996	1,912						28
29	Fire Alarm Repair/Replace			1996	8,069						29
30	Kitchen Floor/Backsplash			1996	1,395						30
31											31
32											32
33											33
34	C/O Allocation							16,231	16,231		34
35	Book Depreciation					263,122		263,122		3,059,866	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-Normal

0048082

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	Tubes--Boiler	1997	\$ 12,279	\$		\$	\$	\$	37
38	Smoke Damper	1997	2,508						38
39	Perimeter Alarm	1997	3,364						39
40	Door Alarm	1997	3,909						40
41	Parking Lot Lights	1997	1,221						41
42	Fire Door	1997	2,146						42
43									43
44	Asbestos Removal	1998	985						44
45	Fire Daper	1998	4,589						45
46	Plumbing Maintenance	1998	3,285						46
47	HVAC Repairs	1998	2,139						47
48	Boiler Retubed	1998	5,720						48
49	Remodel Resident Rooms and Halls-materials	1998	739,117						49
50	Remodel Resident Rooms and Halls- Labor	1998	4,323						50
51	Remodel Resident Rooms and Halls-Professional Fees	1998	38,935						51
52									52
53	Moving Furnature Expense	1998	6,398						53
54	Computer Room Work	1998	896						54
55	Alzheimers Addition-Materials	1998	876,511						55
56	Alzheimers Addition-Labor	1998	516						56
57	Alzheimers Addition-Professional Fees	1998	162,266						57
58	Ventalation System-Materials	1998	54,231						58
59	Ventalation System-Professional Fees	1998	33,010						59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,277,428	\$ 263,122		\$ 279,353	\$ 16,231	\$ 3,059,866	70

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

Facility Name & ID Number Heritage Manor-Normal

0048082

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		\$ 5,277,428	\$ 263,122		\$ 279,353	\$ 16,231	\$ 3,059,866	1
2	Alzheimers Addition-Materials	1999	1,913,384						2
3	Alzheimers Addition-Labor	1999	16,393						3
4	Alzheimers Addition-Professional Fees	1999	43,955						4
5	Ventilation System-Materials	1999	2,591						5
6	Remodel Resident Rooms--Materials	1999	96,197						6
7	Remodel Resident Rooms--Professional Fees	1999	350						7
8	Patio Replacement	1999	3,700						8
9	WAN Room Renovation	1999	3,230						9
10	ALTA Survey	1999	5,488						10
11	PANIC Hardware	1999	1,941						11
12	Roof Work	1999	4,844						12
13	Boiler Replacement	1999	11,219						13
14	Garage Door	1999	985						14
15	West End Renovations-Labor	1999	2,184						15
16	Assisted Living Professional Fees	1999	1,843						16
17									17
18	West Wing Outlets	2000	8,485						18
19	Alzheimer Unit Flooring	2000	5,631						19
20	Accordian Door and Installation	2000	9,600						20
21	Air conditioning Units (2)	2000	1,240						21
22	Exterior Door Replacement	2000	6,095						22
23	Air conditioner -- Dishroom	2000	12,041						23
24	HVAC temp Control	2000	16,220						24
25	Mop sink and faucet (2)	2000	3,377						25
26	Clinical Sink	2000	847						26
27	Eye Wash Stations	2000	2,566						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,451,834	\$ 263,122		\$ 279,353	\$ 16,231	\$ 3,059,866	34

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

Facility Name & ID Number Heritage Manor-Normal

0048082

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		\$ 7,451,834	\$ 263,122		\$ 279,353	\$ 16,231	\$ 3,059,866	1
2	West End Renovations-Labor	2000	9,940						2
3	West End Renovations-material	2000	7,991						3
4									4
5	Boiler Repair	2001	7,921						5
6	Code Alert	2001	6,248						6
7	Painting & Wallpaper Hallway	2001	2,714						7
8	Condenser	2001	3,203						8
9	Fire System Repair	2001	2,269						9
10	Sign	2001	3,266						10
11	Water Heater	2001	4,797						11
12									12
13	Smoke Detector	2002	2,000						13
14	Fence	2002	2,400						14
15	Mixing Valve	2002	2,000						15
16	Bathroom Repairs	2002	10,179						16
17	Sprinkler System	2002	1,019						17
18	Computer Cable	2002	1,076						18
19	Boiler Pump	2002	5,000						19
20	A/C Unit	2002	2,750						20
21	Administrator Office Remodel	2002	4,534						21
22	Fire System Repair	2002	1,234						22
23	A/C Repair	2002	3,535						23
24	Flag & Flag Pole	2002	600						24
25	Elevator Repairs	2002	6,862						25
26	Code Alert	2002	975						26
27	Exhaust Fan	2002	1,350						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,545,697	\$ 263,122		\$ 279,353	\$ 16,231	\$ 3,059,866	34

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

Facility Name & ID Number Heritage Manor-Normal

0048082

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 12C, Carried Forward		\$ 7,545,697	\$ 263,122		\$ 279,353	\$ 16,231	\$ 3,059,866	1
2	Fire System	2003	8,614						2
3	Flag Pole	2003	490						3
4	Security Door	2003	5,990						4
5	A/C Unit	2003	1,580						5
6	Condensing Unit	2003	1,137						6
7	Compressor	2003	2,067						7
8	Sewage Ejection	2003	17,028						8
9	A/C Unit	2003	1,628						9
10									10
11	Sewage Ejection	2004	12,312						11
12	A/C Unit	2004	1,175						12
13	Water Softener	2004	18,667						13
14	Exterior Referbish	2004	2,202						14
15	Boiler	2004	16,060						15
16									16
17	Boiler	2005	388						17
18	Nurses Station	2005	8,146						18
19	Smoke Detectors	2005	3,884						19
20	Windows	2005	6,146						20
21	Tempering Valve	2005	2,510						21
22	Sewage Ejection	2005	1,310						22
23	Ansul System	2005	2,320						23
24	Accelerator	2005	1,548						24
25	A/C Unit	2005	2,550						25
26	A/C Unit	2005	1,275						26
27	Sidewalk Replacement	2005	21,297						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,686,021	\$ 263,122		\$ 279,353	\$ 16,231	\$ 3,059,866	34

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

Facility Name & ID Number Heritage Manor-Normal

0048082

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 12D, Carried Forward		\$ 7,686,021	\$ 263,122		\$ 279,353	\$ 16,231	\$ 3,059,866	1
2									2
3	A/C Unit	2006	5,900						3
4	Phone System	2006	1,418						4
5	Door	2006	1,613						5
6									6
7	Interior Door	2007	425						7
8	Generator	2007	16,165						8
9	Mixing valve	2007	1,955						9
10	Water pipe	2007	2,350						10
11	Water Heater	2007	27,451						11
12	Window	2007	906						12
13	AC Condensing Unit	2007	2,345						13
14	Flooring	2007	775						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)		\$ 7,747,324	\$ 263,122		\$ 279,353	\$ 16,231	\$ 3,059,866	34

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

Facility Name & ID Number Heritage Manor-Normal # 0048082 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	\$ 1,171,103	\$ 23,879	\$ 23,879	\$		\$ 1,181,826	71
72	Current Year Purchases	30,459						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,201,562	\$ 23,879	\$ 23,879	\$		\$ 1,181,826	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)	\$ 9,009,573	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 287,001	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 303,232	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,231	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,241,692	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:		164	07/2006	\$ 359,160	5		3
4	Additions							4
5								5
6								6
7	TOTAL		164		\$ 359,160			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>359,160</u>
13.	<u>/2009</u>	\$ <u>359,160</u>
14.	<u>/2010</u>	\$ <u>359,160</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: \$ 6,207 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		2,405		2,405
3	Classroom Wages (a)		21,927		21,927
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 24,332	\$	\$ 24,332
10	SUM OF line 9, col. 1 and 2 (e)	\$	24,332		

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-Normal# 0048082 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	\$		\$ 213,728	\$		\$ 213,728	1
2	Licensed Speech and Language Development Therapist		hrs			3,074			3,074	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			303,370	307		303,677	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				405,124		405,124	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					14,230			14,230	13
14	TOTAL			\$		\$ 534,402	\$ 405,431		\$ 939,833	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-Normal # 0048082 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	\$ 426	\$	1
2	Cash-Patient Deposits	18,542		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	726,066		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,515		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	726,688		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,494,237	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	181,333		13
14	Buildings, at Historical Cost	7,413,853		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,262,993		16
17	Accumulated Depreciation (book methods)	(4,241,692)		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):	27,009		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,643,496	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,137,733	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 174,815	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,542		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	363,652		30
31	Accrued Taxes Payable (excluding real estate taxes)	48,589		31
32	Accrued Real Estate Taxes(Sch.IX-B)	133,659		32
33	Accrued Interest Payable	35,154		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)	\$ 774,411	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,322,282		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)	\$ 5,322,282	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,096,693	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 41,040	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,137,733	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (102,851)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (102,851)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	293,891	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	(150,000)	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)	\$ 143,891	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)	\$ 41,040	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Normal# 0048082Report 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	\$ 7,897,910	1
2	Discounts and Allowances for all Levels	(1,873,142)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,024,768	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,680,517	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,680,517	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	140	12
13	Barber and Beauty Care	3,875	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	50	16
17	Sale of Drugs	610,609	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)	\$ 614,674	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,426	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,426	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	other	(17,000)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (17,000)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,304,385	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,502,693	31
32	Health Care	3,933,617	32
33	General Administration	1,775,454	33
B. Capital Expense			
34	Ownership	798,730	34
C. Ancillary Expense			
35	Special Cost Centers		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)*	\$ 8,010,494	40
41	Income before Income Taxes (line 30 minus line 40)**	293,891	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 293,891	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-Normal

0048082

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	1,960	2,080	\$ 54,720	\$ 26.31	1
2	Assistant Director of Nursing	1,224	1,614	30,873	19.13	2
3	Registered Nurses	12,240	12,924	334,350	25.87	3
4	Licensed Practical Nurses	28,070	30,144	583,705	19.36	4
5	CNAs & Orderlies	118,693	123,641	1,473,199	11.92	5
6	CNA Trainees	2,200	2,200	21,927	9.97	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,894	4,327	60,613	14.01	8
9	Activity Director					9
10	Activity Assistants	12,568	13,217	133,323	10.09	10
11	Social Service Workers	2,109	2,221	42,273	19.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	44,996	47,062	420,810	8.94	15
16	Dishwashers					16
17	Maintenance Workers	14,182	15,256	149,731	9.81	17
18	Housekeepers	21,621	22,402	179,865	8.03	18
19	Laundry	12,054	12,896	115,143	8.93	19
20	Administrator	1,900	2,080	76,176	36.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,412	15,951	243,407	15.26	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)	292,123	308,015	\$ 3,920,115 *	\$ 12.73	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	1,793		37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,920		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	3,918		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 20,231		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	25	\$ 1,016	50
51	Licensed Practical Nurses	1,183	41,409	51
52	Certified Nurse Assistants/Aides	1,580	39,502	52
53	TOTAL (lines 50 - 52)	2,789	\$ 81,927	53

Facility Name & ID Number Heritage Manor-Normal

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 Normal 38281 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 89,790
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. \$ 31,998
- (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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