

Facility Name & ID Number Heritage Nursing Center

0042440 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	4 Other	5 Total	
8	SNF	10,267	6,549	1,405	18,221	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,267	6,549	1,405	18,221	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.20%

D. How many bed-hold days during this year were paid by the Department? None (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)
None

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 Non-allowable costs have been eliminated in Schedule V, Column 7

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 12/01/1996

J. Was the facility purchased or leased after January 1, 1978?
YES Date 12/01/1996 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 12 and days of care provided 1,405

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Heritage Nursing Center # 0042440 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	122,590	8,773	1,477	132,840		132,840		132,840		1
2	Food Purchase		72,861		72,861		72,861		72,861		2
3	Housekeeping	71,406	27,148		98,554		98,554		98,554		3
4	Laundry	22,979	5,973		28,952		28,952		28,952		4
5	Heat and Other Utilities			106,993	106,993		106,993		106,993		5
6	Maintenance	39,803	16,775	14,293	70,871		70,871		70,871		6
7	Other (specify):*										7
8	TOTAL General Services	256,778	131,530	122,763	511,071		511,071		511,071		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	696,376	83,819	1,315	781,510		781,510		781,510		10
10a	Therapy			90,234	90,234		90,234		90,234		10a
11	Activities	20,623	8,614	3,425	32,662		32,662		32,662		11
12	Social Services	29,456		513	29,969		29,969		29,969		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	746,455	92,433	106,287	945,175		945,175		945,175		16
	C. General Administration										
17	Administrative	57,994		34,000	91,994		91,994		91,994		17
18	Directors Fees										18
19	Professional Services			39,329	39,329		39,329	(25,000)	14,329		19
20	Dues, Fees, Subscriptions & Promotions			10,254	10,254		10,254		10,254		20
21	Clerical & General Office Expenses	23,947	19,789	17,228	60,964		60,964	(97)	60,867		21
22	Employee Benefits & Payroll Taxes			198,933	198,933		198,933		198,933		22
23	Inservice Training & Education			26	26		26		26		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			3,592	3,592		3,592		3,592		25
26	Insurance-Prop.Liab.Malpractice			40,242	40,242		40,242	52,361	92,603		26
27	Other (specify):*										27
28	TOTAL General Administration	81,941	19,789	343,604	445,334		445,334	27,264	472,598		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,085,174	243,752	572,654	1,901,580		1,901,580	27,264	1,928,844		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 Nursing Center

#0042440

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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			1,639	1,639		1,639	55,669	57,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							110,699	110,699			32
33	Real Estate Taxes							49,051	49,051			33
34	Rent-Facility & Grounds			224,067	224,067		224,067	(224,067)				34
35	Rent-Equipment & Vehicles			24,896	24,896		24,896		24,896			35
36	Other (specify):*											36
37	TOTAL Ownership			250,602	250,602		250,602	(8,648)	241,954			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		33,901		33,901		33,901		33,901			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,150	30,150		30,150		30,150			42
43	Other (specify):* Non-allowable Cos		21	29,213	29,234		29,234	(29,234)				43
44	TOTAL Special Cost Centers		33,922	59,363	93,285		93,285	(29,234)	64,051			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,085,174	277,674	882,619	2,245,467		2,245,467	(10,618)	2,234,849			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Heritage Nursing Center

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Report Period Beginning:

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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	(3,793)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,404	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(300)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(25,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,561)	43		24
25	Fund Raising, Advertising and Promotional	(3,116)	43		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 <u>See Pg. 5A</u>	(3,561)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (42,929)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	32,311		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 32,311		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (10,618)		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.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Heritage Nursing Center

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,362)	43	1
2	X-Rays-Part A	(471)	43	2
3	Disallowed Special Events	(631)	43	3
4	Miscellaneous Revenue Offset of Office Supplies	(97)	21	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				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	(3,561)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Nursing Center# 0042440

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(25,000)	0	0	0	0	0	0	0	0	0	0	(25,000)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(97)	0	0	0	0	0	0	0	0	0	0	(97)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	52,361	0	0	0	0	0	0	0	0	0	52,361	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(25,097)	52,361	0	0	0	0	0	0	0	0	0	27,264	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(25,097)	52,361	0	0	0	0	0	0	0	0	0	27,264	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Nursing Center# 0042440

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	11,404	44,265	0	0	0	0	0	0	0	0	0	55,669	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2)	110,701	0	0	0	0	0	0	0	0	0	110,699	32
33	Real Estate Taxes	0	49,051	0	0	0	0	0	0	0	0	0	49,051	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	(224,067)	0	0	0	0	0	0	0	0	0	(224,067)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	11,402	(20,050)	0	(8,648)	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):*	(29,234)	0	0	0	0	0	0	0	0	0	0	(29,234)	43
44	TOTAL Special Cost Centers	(29,234)	0	0	0	0	0	0	0	0	0	0	(29,234)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(42,929)	32,311	0	(10,618)	45								

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
Avigdor Horowitz	100	Jackson Heights Nursing Home	Farmer City	Heritage Nursing Center, LLC	Champaign	Lessor

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	26 Property Insurance	\$	Heritage Nursing Center, LLC	100.00%	\$ 43,981	\$ 43,981	1
2	V	26 Mortgage Insurance		Heritage Nursing Center, LLC	100.00%	8,380	8,380	2
3	V	30 Depreciation		Heritage Nursing Center, LLC	100.00%	44,265	44,265	3
4	V	32 Amortization		Heritage Nursing Center, LLC	100.00%	5,262	5,262	4
5	V	32 Interest		Heritage Nursing Center, LLC	100.00%	105,439	105,439	5
6	V	33 Real Estate Taxes		Heritage Nursing Center, LLC	100.00%	49,051	49,051	6
7	V	35 Rent-Facility & Grounds	224,067	Heritage Nursing Center, LLC	100.00%		(224,067)	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 224,067			\$ 256,378	\$ * 32,311	14

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

Facility Name & ID Number

Heritage Nursing Center

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Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	N/A								\$	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	\$	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 Nursing Center

0042440 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	N/A				\$	\$		\$	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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Heritage Nursing Center

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12/31/2007

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										
										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	Capmark	X	Mortgage	\$9,536.20	08/01/02	\$ 1,615,000	\$ 1,536,284	9/1/37	0.0630	\$ 105,439	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$9,536.20		\$ 1,615,000	\$ 1,536,284			\$ 105,439	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$ 5,260	14								
15	TOTALS (line 9+line14)					\$ 1,615,000	\$ 1,536,284			\$ 110,699	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 8,380 Line # 26

* 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.)

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12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,312 B. General Construction Type: Exterior Brick Frame Block 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).

N/A

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1996</u>	<u>\$ 41,400</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 41,400	3

Facility Name & ID Number Heritage Nursing Center# 0042440

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60	1996	1974	\$ 979,800	\$	27.5	\$ 35,629	\$ 35,629	\$ 391,919	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Parking Lot Paving		1997	16,431		39	421	421	4,368	9
10	Water Heater		1997	4,300		39	110	110	1,196	10
11	Laundry Repair		1997	1,633		39	42	42	446	11
12	Remodeling		1997	33,803		39	867	867	9,139	12
13	Remodeling		1997	22,305		27.5	811	811	8,482	13
14	Paving		1998	2,900		39	74	74	712	14
15	Tiling		1999	38,000		27.5	1,382	1,382	11,804	15
16	Garden		1999	35,912		27.5	1,306	1,306	11,155	16
17	Birdhouse		1999	4,043		27.5	147	147	1,194	17
18	Tuckpointing		1999	36,200		27.5	1,316	1,316	11,131	18
19	Windows		1999	49,227		27.5	1,790	1,790	14,693	19
20	Parking Lot Paving		1999	5,900		27.5	215	215	1,764	20
21	Shed		1999	12,000		27.5	436	436	3,688	21
22	Steam Table		1999	3,000		27.5	109	109	922	22
23	Windows		2000	30,922		27.5	1,124	1,124	8,946	23
24	Roof Repair		2003	4,160		39	107	107	477	24
25	Blinds		2007	4,571		10	229	229	229	25
26	Water Heaters		2007	11,705		15	390	390	390	26
27	New Roof		2007	30,000		20	750	750	750	27
28										28
29										29
30										30
31										31
32										32
33	Building Improvements Booked				1,300			(1,300)		33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	37	
38								38	
39								39	
40								40	
41								41	
42								42	
43								43	
44								44	
45								45	
46								46	
47								47	
48								48	
49								49	
50								50	
51								51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								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)		\$ 1,326,812	\$ 1,300		\$ 47,255	\$ 45,955	\$ 483,405	70

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

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	\$ 404,926	\$	\$ 9,883	\$ 9,883	10	\$ 404,926	71
72	Current Year Purchases	3,395	339	170	(169)		170	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 408,321	\$ 339	\$ 10,053	\$ 9,714		\$ 405,096	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,776,533	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,639	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,308	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 55,669	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 888,501	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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: N/A *

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: \$ 4,709 Description: See Attached Schedule 14A

(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	<u>Administrative</u>	<u>Various</u>	\$ <u>Various</u>	\$ <u>20,187</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>20,187</u>	21

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 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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 checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,378	\$ 50,675	\$	3,378	\$ 50,675	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		47	711		47	711	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,590	38,848		2,590	38,848	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				33,901		33,901	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	6,015	\$ 90,234	\$ 33,901	6,015	\$ 124,135	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 Nursing Center# 0042440Report Period Beginning: 01/01/2007Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ (89,997)	\$ (89,797)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	611,672	611,672	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,451	9,451	6
7	Other Prepaid Expenses	108,062	2,683	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Mortgage Escrows</u>		243,140	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 639,188	\$ 777,149	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		41,400	13
14	Buildings, at Historical Cost		979,800	14
15	Leasehold Improvements, at Historical Cost	65,334	347,012	15
16	Equipment, at Historical Cost	5,599	408,321	16
17	Accumulated Depreciation (book methods)	(1,639)	(888,501)	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 (spe <u>Loan Costs</u>)		156,117	22
23	Other(specify): <u>Security Deposit</u>	50,000	50,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 119,294	\$ 1,094,149	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 758,482	\$ 1,871,298	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 748,029	\$ 748,029	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,592	37,592	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,151	3,151	31
32	Accrued Real Estate Taxes(Sch.IX-B)		25,000	32
33	Accrued Interest Payable		8,065	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	16,075	16,075	36
37	<u>Due to Manager</u>	50,000	50,000	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 854,847	\$ 887,912	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,536,284	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Related Parties</u>	156,548	156,548	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 156,548	\$ 1,692,832	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,011,395	\$ 2,580,744	46
47	TOTAL EQUITY(page 18, line 24)	\$ (252,913)	\$ (709,446)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 758,482	\$ 1,871,298	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (83,189)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (83,189)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(169,724)	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	()	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)	\$ (169,724)	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)	\$ (252,913)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Nursing Center# 0042440Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	\$ 1,843,014	1
2	Discounts and Allowances for all Levels	(29,510)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,813,504	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	206,504	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 206,504	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	60,640	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,176	20
21	Other Medical Services	(6,180)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 55,636	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	97	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 97	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,075,743	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	511,071	31
32	Health Care	945,175	32
33	General Administration	445,334	33
B. Capital Expense			
34	Ownership	250,602	34
C. Ancillary Expense			
35	Special Cost Centers	63,135	35
36	Provider Participation Fee	30,150	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,245,467	40
41	Income before Income Taxes (line 30 minus line 40)**	(169,724)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (169,724)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 Nursing Center**

0042440

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	2,343	2,367	\$ 57,786	\$ 24.41	1
2	Assistant Director of Nursing	560	560	14,561	26.00	2
3	Registered Nurses	2,700	2,787	67,712	24.30	3
4	Licensed Practical Nurses	7,582	7,751	161,733	20.87	4
5	CNAs & Orderlies	38,399	39,063	389,465	9.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,536	2,559	20,623	8.06	10
11	Social Service Workers	2,508	2,508	29,456	11.74	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,128	33,441	15.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,575	10,768	89,149	8.28	15
16	Dishwashers					16
17	Maintenance Workers	3,044	3,052	39,803	13.04	17
18	Housekeepers	8,146	8,271	71,406	8.63	18
19	Laundry	2,789	2,823	22,979	8.14	19
20	Administrator	2,277	2,357	57,994	24.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,326	2,326	23,947	10.30	23
24	Clerical					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	602	602	5,119	8.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	88,467	89,922	\$ 1,085,174 *	\$ 12.07	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	28	\$ 1,477	1(3)	35
36	Medical Director	Monthly	10,800	9(3)	36
37	Medical Records Consultant	Monthly	405	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	350	10(3)	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	28	\$ 13,032		49

C. CONTRACT NURSES

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

Facility Name & ID Number Heritage Nursing Center

0042440

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 Council on LTC-\$1,455
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,625 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 30,150
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? No 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? N/A Indicate the amount. \$ 0
- (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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients?
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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.

**Heritage Nursing Center
0042440**

**Period Beginning 1/31/2007
Period Ending 12/31/2007**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	1,566
Dishwasher		416
Copier		<u>2,727</u>
		<u><u>4,709</u></u>

Heritage Nursing Center
0042440

Period Beginning 1/31/2007
Period Ending 12/31/2007

Schedule 21A

Professional Services

Vendor	Type	Amount
Daniel Malone	Accounting Services	2,355
Misc. Vendors	Accounting Services	954
Haven Mgmt.	Accounting Services	2,750
Richard Peelo & Associates	Accounting Services	2,100
Personnel Planners	Accounting Services	462
Medifax	Computer Services	725
Insight Communications	Computer Services	1,833
LTC Solutions	Computer Services	660
Omnicare	Computer Services	890
E-Health Data Solutions	Computer Services	1,600
Ken Ashman Law Offices	Legal Services	25,000
		<u>39,329</u>
	Disallowed Legal Fees	<u>(25,000)</u>
	Total Sch. V, Line 19, Col. 8	<u><u>14,329</u></u>

Heritage Nursing Center
0042440

Period Beginning 1/31/2007
Period Ending 12/31/2007

Page 3, Line 25, Column 8
Other Administrative Staff Transportation

Repairs to Vehicles	601
Gas Reimbursement	<u>2,991</u>
	3,592
Home Office Allocation	<u>-</u>
Total Other Administrative Staff Transportation	<u><u>3,592</u></u>