

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0018176

Facility Name: Heritage Square

Address: 620 North Ottawa Avenue Dixon 61021
 Number City Zip Code

County: Lee

Telephone Number: 815-288-6276 **Fax #** 815-288-6821

HFS ID Number: 36-605435-7001

Date of Initial License for Current Owners: 11/08/74

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501© (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: Norman J. Gross, Admn. **Telephone Number:** 815-288-2251
J.O'Farrell, Bookkeeper

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Norman J. Gross</u>	
	(Title) <u>Administrator</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>N/A</u>	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

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

Facility Name & ID Number Heritage Square

0018176 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>25</u>	Skilled (SNF)	<u>27</u>	<u>9,151</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>49</u>	Sheltered Care (SC)	<u>49</u>	<u>17,885</u>	5
6		ICF/DD 16 or Less			6
7	<u>74</u>	TOTALS	<u>76</u>	<u>27,036</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	<u>1,727</u>	<u>7,036</u>		<u>8,763</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>15,611</u>		<u>15,611</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,727</u>	<u>22,647</u>		<u>24,374</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.15%

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)
0

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 11/07/1974

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Heritage Square # 0018176 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	234,671	23,005	1,990	259,666		259,666	(3,607)	256,059			1
2	Food Purchase		188,273		188,273		188,273	(11,788)	176,485			2
3	Housekeeping	101,688	12,369	662	114,719		114,719	(2,115)	112,604			3
4	Laundry	23,065	7,100		30,165		30,165		30,165			4
5	Heat and Other Utilities			97,782	97,782		97,782		97,782			5
6	Maintenance	90,040	33,567		123,607		123,607		123,607			6
7	Other (specify):* Waste Removal			2,513	2,513		2,513		2,513			7
8	TOTAL General Services	449,464	264,314	102,947	816,725		816,725	(17,510)	799,215			8
	B. Health Care and Programs											
9	Medical Director			2,050	2,050		2,050		2,050			9
10	Nursing and Medical Records	824,563	22,792	1,220	848,575		848,575	(48,563)	800,012			10
10a	Therapy	34,696		1,885	36,581		36,581		36,581			10a
11	Activities	76,918	4,993	2,827	84,738		84,738		84,738			11
12	Social Services	43,200	971	443	44,614		44,614		44,614			12
13	CNA Training											13
14	Program Transportation		1,469	3,548	5,017		5,017		5,017			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	979,377	30,225	11,973	1,021,575		1,021,575	(48,563)	973,012			16
	C. General Administration											
17	Administrative	76,000			76,000		76,000		76,000			17
18	Directors Fees											18
19	Professional Services			12,525	12,525		12,525	(1,497)	11,028			19
20	Dues, Fees, Subscriptions & Promotions			43,761	43,761		43,761	(37,305)	6,456			20
21	Clerical & General Office Expenses	91,010	11,586	27,301	129,897		129,897	(15,171)	114,726			21
22	Employee Benefits & Payroll Taxes			327,616	327,616		327,616		327,616			22
23	Inservice Training & Education											23
24	Travel and Seminar			540	540		540		540			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			81,980	81,980		81,980		81,980			26
27	Other (specify):*											27
28	TOTAL General Administration	167,010	11,586	493,723	672,319		672,319	(53,973)	618,346			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,595,851	306,125	608,643	2,510,619		2,510,619	(120,046)	2,390,573			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 Square #0018176 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			122,878	122,878	122,878		122,878			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			150	150	150	(455,730)	(455,580)			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			123,028	123,028	123,028	(455,730)	(332,702)			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			13,688	13,688	13,688	13,688	27,376			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			13,688	13,688	13,688	13,688	27,376			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,595,851	306,125	745,359	2,647,335	2,647,335	(562,088)	2,085,247			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 Square

0018176

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	11,788	-A-2-7		4
5	Telephone, TV & Radio in Resident Rooms	11,945	-C-21-7		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	455,730	-D-32-7		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				18
19	Entertainment				19
20	Contributions	485	-C-21-7		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	1,497	-C3-19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	37,305	-C-20-7		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	2,741	-C-21-7		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 521,491		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 521,491		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 Square

ID# 0018176
 Report Period Beginning: 01/01/07
 Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Accrued Dietary payroll	\$ 3,607	V-A-1-7	1
2	Accrued Housekeeping Payroll	2,115	V-A-3-7	2
3	Accrued Nursing Payroll	48,563	V-B-10-7	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	54,285		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Square

0018176

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	(3,607)	0	0	0	0	0	0	0	0	0	0	(3,607)	1
2	Food Purchase	(11,788)	0	0	0	0	0	0	0	0	0	0	(11,788)	2
3	Housekeeping	(2,115)	0	0	0	0	0	0	0	0	0	0	(2,115)	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	(17,510)	0	0	0	0	0	0	0	0	0	0	(17,510)	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	(48,563)	0	0	0	0	0	0	0	0	0	0	(48,563)	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	(48,563)	0	0	0	0	0	0	0	0	0	0	(48,563)	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	(1,497)	0	0	0	0	0	0	0	0	0	0	(1,497)	19
20	Fees, Subscriptions & Promotions	(37,305)	0	0	0	0	0	0	0	0	0	0	(37,305)	20
21	Clerical & General Office Expenses	(15,171)	0	0	0	0	0	0	0	0	0	0	(15,171)	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(53,973)	0	0	0	0	0	0	0	0	0	0	(53,973)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(120,046)	0	0	0	0	0	0	0	0	0	0	(120,046)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Square

0018176

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	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	122,878	0	0	0	0	0	0	0	0	0	0	122,878	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(455,730)	0	0	0	0	0	0	0	0	0	0	(455,730)	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	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(332,852)	0	(332,852)	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	13,688	0	0	0	0	0	0	0	0	0	0	13,688	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	13,688	0	13,688	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(439,210)	0	(439,210)	45									

Facility Name & ID Number Heritage Square

0018176

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Heritage Square # 0018176 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									\$		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 Square

0018176 Report Period Beginning: 01/01/07 Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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	Amnity Interest		X	Annuity	Annual					\$ 150	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$		\$ 150	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 150	15									

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

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

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

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

B. Real Estate Taxes

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

NOTES:

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

IMPORTANT NOTICE

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

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

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

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

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Square COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0018176

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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 Square

0018176 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,354 B. General Construction Type: Exterior Brick Frame Steel Griders,Metal La Number of Stories 2

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).

1. Warner Campus - 2 Free Standing Buildings which equals 4 units

2. Each of the above 4 units equal 1160 s. ft. each, plus garage.

(Above information taken from architect prints.)

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>Home for Aged</u>	<u>97,046</u>	<u>1963</u>	<u>\$ 42,888</u>	<u>1</u>
2				<u>31,315</u>	<u>2</u>
3	TOTALS	97,046		\$ 74,203	3

Facility Name & ID Number Heritage Square

0018176

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			1974	1974	\$ 1,532,081	\$ 38,302	40	\$ 38,302		\$ 1,273,639	4
5			1993	1993	1,100,199	27,505	40	27,505		398,822	5
6											6
7											7
8											8
		Improvement Type**									
9		Outdoor Lights		1977	696		20			696	9
10		Patio Cover		1980	3,729		10			3,729	10
11		Storeroom Sprinkler		1981	1,309		20			1,309	11
12		P.T. & Rehab.Rm.		1985	18,461		18			18,461	12
13		L.L.Act.(Reassigned B.SP.)		1985	3,229		19			3,229	13
14		Soc.Service Office		1988	1,319	63	20	63		1,299	14
15		Roof (HCC Wing)		1988	5,940		15			5,940	15
16		Parking Lot		1989	11,398	541	20	541		10,372	16
17		Gutter & Downspouts (S.Wing)		1991	4,500		15			4,500	17
18		Plumbing Replacement		1991	2,099	99	20	99		1,700	18
19		Storage Shed		1991	1,189	56	20	56		961	19
20		Fire Alarm Improvements		1991	1,630	77	20	77		1,322	20
21		Intercom Improvements		1992	508	28	15	28		508	21
22		Fire Protection Beams		1993	1,380		10			1,380	22
23		Concrete Walk & Driveway		1993	6,008	374	15	374		5,750	23
24		Landscaping (New Wing)		1993	7,749		10			7,749	24
25		Resurface Parking Lot		1993	17,716	1,102	15	1,102		16,614	25
26		Gutter & Downspouts (N.Wing)		1993	3,600	224	15	224		3,384	26
27		Heating (HCC Floor)		1994	3,966		10			3,966	27
28		Elevator Safety Shield		1994	1,250		10			1,250	28
29		Concrete Walk & Bench Pad		1994	1,225	58	20	58		838	29
30		Painting Facia of Building		1994	1,955		5			1,955	30
31		Life Safety Door Closer (replace)		1995	4,432	276	15	276		3,569	31
32		Patio Sidewalk (Replace		1995	6,507	309	20	309		3,968	32
33		Soffit Repair (Vinyl)		1995	4,100	195	20	195		2,502	33
34		Attic Ventilation (S. Wing in SC)		1996	11,600	551	20	551		6,496	34
35		Exterior Walks & Drive		1996	3,809	181	20	181		2,132	35
36		(Cont'd on page 12-A)									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 Square

0018176

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	N.E. Outdoor Storage shed	1996	\$ 707	\$ 34	20	\$ 34	\$	\$ 395	37
38	Lighting Replacement (Energy Efficient)	1997	13,031	811	15	811		8,775	38
39	Radiant Heat Panels (S.C.)	1998	19,894	1,790	10	1,790		17,870	39
40	Bed Runner Guards (HCC)	1998	765	765	5	765		765	40
41	Kitchen Fire System	1998	898	43	20	43		395	41
42	8 Attice Exhaust Fans (S.C.)	1998	6,356	301	20	301		2,871	42
43	Painting	1999	11,227		5			11,227	43
44	Deposit Bldg.Extens.	2000	2,346						44
45	GFI Electrical Upgrades	2000	4,800	228	20	228		1,628	45
46	Paint Halls & Doors	2001	5,970	99	5	99		5,970	46
47	New South Roof	2002	171,935	5,732	30	5,732		30,089	47
48	New Roof	2003	140,137	4,671	30	4,671		19,463	48
49	Replacement of Clay Tile & Pvc	2005	1,153	38	30	38		99	49
50	Repair & Replace No.Driveway	2005	9,330	622	15	622		1,296	50
51	Bathroom Tile	2005	1,500	75	20	75		213	51
52	Repair & Waterproof Balcony	2005	6,500	325	20	325		785	52
53	Exit/Cylinder Change Room Doors	2005	4,426	221	20	221		535	53
54	Prime & Paint Handrail on Bldg.	2005	3,360	336	10	336		756	54
55	New Locks on half the Resident doors	2006	2,897	85	20	85		229	55
56	Carpet for Offices & Entrance	2006	7,307	852	5	852		2,314	56
57	Concrete Work	2006	2,595	58	15	58		231	57
58	Automatic Door for Courtyard	2006	2,665	22	20	22		155	58
59	Asphalt Half circle driveway	2006	2,300	38	15	38		192	59
60	Carpet for Resident/Hallways	2007	3,014	176	10	176		176	60
61	Metal Wall	2007	9,523	317	20	317		317	61
62	Commodes	2007	1,366	91	10	91		91	62
63	Landscaping/Flowers	2007	250	49	3	49		49	63
64	Fire Alarm Control Panel	2007	8,000	467	10	467		467	64
65	Smoke Detectors/horns/strobes	2007	8,763	438	10	438		438	65
66	Concrete Patio	2007	5,860	147	20	147		147	66
67	Wall Station Dukane 4A1225	2007	723	60	5	60		60	67
68	Floor Pedal Sink	2007	380	16	10	16		16	68
69	Cont'd on Page 12B								69
70	TOTAL (lines 4 thru 69)		\$ 3,223,562	\$ 88,848		\$ 88,848	\$	\$ 1,896,054	70

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

Facility Name & ID Number Heritage Square

0018176

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		\$ 3,223,562	\$ 88,848		\$ 88,848	\$	\$ 1,896,054	1
2	Actuator (Lifts) - 2	2007	1,072	36	10	36		36	2
3	IDPH Fire Improvements	2007	8,755		20				3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,233,389	\$ 88,884		\$ 88,884	\$	\$ 1,896,090	34

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

Facility Name & ID Number Heritage Square # 0018176 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	\$ 555,425	\$ 27,484	\$ 27,484	\$		\$ 365,024	71
72	Current Year Purchases	47,706	3,257	3,257			3,257	72
73	Fully Depreciated Assets							73
74	Less Dispostions	(6,286)					(6,286)	74
75	TOTALS	\$ 596,845	\$ 30,741	\$ 30,741	\$		\$ 361,995	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	Patient Transport	2001 Grand Marquis Mercury	2005	\$ 13,011	\$ 3,253	\$ 3,253	\$	4	\$ 6,777	76
77										77
78										78
79										79
80	TOTALS			\$ 13,011	\$ 3,253	\$ 3,253	\$		\$ 6,777	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)	\$ 3,917,448	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 122,878	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 122,878	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,264,862	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: _____

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ _____ 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 checked="" 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				
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.

Facility Name & ID Number Heritage Square# 0018176 Report Period Beginning:01/01/07 Ending:12/31/07

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$	\$		\$	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 Square # 0018176 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	\$ 3,011,881	\$	1
2	Cash-Patient Deposits	23,999		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at <u>Cost</u>)	23,384		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,840		6
7	Other Prepaid Expenses	4,071		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest</u>	6,294		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,092,469	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	138,470		11
12	Long-Term Investments	1,196,192		12
13	Land	74,203		13
14	Buildings, at Historical Cost	3,233,391		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	583,254		16
17	Accumulated Depreciation (book methods)	(2,331,378)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	447,177		21
22	Other Long-Term Assets (spe <u>Int.Prepetual Trust</u>)	5,694,280		22
23	Other(specify): <u>R.L.Warner Campus</u>	188,305		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,223,894	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,316,363	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 34,062	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,686		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 186,748	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Gift Annuity</u>	1,000		43
44	<u>Self Insured Health</u>	3,000		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 190,748	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,125,615	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 12,316,363	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,398,170	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,398,170	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	727,445	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)	\$ 727,445	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)	\$ 12,125,615	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Square# 0018176Report Period Beginning: 01/01/07Ending: 12/31/07**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,389,805	1
2	Discounts and Allowances for all Levels	(149,576)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,240,229	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	18,721	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 18,721	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	352	12
13	Barber and Beauty Care	1,822	13
14	Non-Patient Meals	9,337	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	18,124	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 29,635	23
D. Non-Operating Revenue			
24	Contributions	4,810	24
25	Interest and Other Investment Income***	455,730	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 460,540	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Beneficial Trust	553,496	28
28a	Gain or Loss on Assets/Stock	72,159	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 625,655	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,374,780	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	816,725	31
32	Health Care	1,021,575	32
33	General Administration	672,319	33
B. Capital Expense			
34	Ownership	123,028	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	13,688	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,647,335	40
41	Income before Income Taxes (line 30 minus line 40)**	727,445	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 727,445	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.

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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	1,944	2,080	\$ 59,732	\$ 28.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,845	7,364	155,967	21.18	3
4	Licensed Practical Nurses	12,153	12,943	239,710	18.52	4
5	CNAs & Orderlies	31,285	32,329	320,591	9.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,741	1,862	34,696	18.63	8
9	Activity Director	1,916	2,080	35,948	17.28	9
10	Activity Assistants	4,792	5,008	40,970	8.18	10
11	Social Service Workers	3,088	3,383	43,200	12.77	11
12	Dietician					12
13	Food Service Supervisor	1,920	2,080	34,616	16.64	13
14	Head Cook	5,716	6,138	56,874	9.27	14
15	Cook Helpers/Assistants	16,413	16,919	124,648	7.37	15
16	Dishwashers	1,847	1,951	14,926	7.65	16
17	Maintenance Workers	3,818	5,930	90,818	15.32	17
18	Housekeepers	10,391	11,017	99,573	9.04	18
19	Laundry	2,938	3,080	23,263	7.55	19
20	Administrator	1,904	2,080	76,000	36.54	20
21	Assistant Administrator					21
22	Other Administrative	2,008	2,088	31,500	15.09	22
23	Office Manager	1,920	2,080	31,345	15.07	23
24	Clerical	2,371	2,496	19,324	7.74	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) <u>Driver</u>	1,093	1,155	8,841	7.65	33
34	TOTAL (lines 1 - 33)	116,103	124,063	\$ 1,542,542 *	\$ 12.43	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	Contract	\$ 1,990	V-A1-3	35
36	Medical Director	Contract	2,050	V-B-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	26	1,170	V-B-10-3	39
40	Physical Therapy Consultant	Contract	1,767	V-B-10a-3	40
41	Occupational Therapy Consultant	6	118	V-B-10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	337	V-B-11-3	44
45	Social Service Consultant	13	337	V-B-12-3	45
46	Other(specify) <u>Chaplain</u>	Contract	1,980	V-B-11-3	46
47	<u>QA Physicians</u>	2	50	V-B-10-3	47
48	<u>Sunday Clergy</u>	34	510	V-B-11-3	48
49	TOTAL (lines 35 - 48)	94	\$ 10,309		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			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Norman J. Gross	Administrator	0	\$ 76,000	Workers' Compensation Insurance	\$ 51,608	IDPH License Fee	\$ 100	
				Unemployment Compensation Insurance	0	Advertising: Employee Recruitment	2,193	
				FICA Taxes	117,789	Health Care Worker Background Check		
				Employee Health Insurance	152,184	(Indicate # of checks performed <u>34</u>)	550	
				Employee Meals		Patient Background Checks <u>12</u>	140	
				Illinois Municipal Retirement Fund (IMRF)*		LSN/AAHSA	3,186	
				Employee Physicals	6,849	Assoc.Dues. INHAA	100	
						IL Activity Prof.Dues	162	
						New Day Activity	25	
						Non-Allowable Total	37,305	
						Less: Public Relations Expense	(968)	
						Non-allowable advertising	(33,596)	
						Yellow page advertising	(2,741)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 76,000	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 328,430		\$ 6,456		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	132
							Seminar Expense	408
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							\$ 540	
C. Professional Services								
Vendor/Payee	Type	Amount						
Clifton & Gunderson	Audit	\$ 9,815						
Clifton & Gunderson	Data Process	1,125						
Ehrmann,Gehlbach,Bader,Lee	Legal	88						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 11,028					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network \$3186.
- (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? _____
- (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? 15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,370 Line B-10-2
- (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 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. \$ 13,688
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. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 11,788
- (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. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? 90%
- 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? N/A
- 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Clifton Gunderson LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.