

Facility Name & ID Number Heritage Manor-Carlinville

0048850 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	108	Skilled (SNF)	108	39,420	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	108	TOTALS	108	39,420	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,311	11,009	3,465	27,785	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,311	11,009	3,465	27,785	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.48%

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)

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 07/2007

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

YES Date 07/2007 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided 3,465

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	171,827	9,540		181,367		181,367	5,945	187,312		1
2	Food Purchase		158,925		158,925		158,925		158,925		2
3	Housekeeping	96,776	19,326		116,102		116,102	22	116,124		3
4	Laundry	47,715	11,553		59,268		59,268		59,268		4
5	Heat and Other Utilities			128,740	128,740		128,740	2,092	130,832		5
6	Maintenance	50,605	61,305	27,482	139,392		139,392	14,887	154,279		6
7	Other (specify):*										7
8	TOTAL General Services	366,923	260,649	156,222	783,794		783,794	22,946	806,740		8
	B. Health Care and Programs										
9	Medical Director			11,554	11,554		11,554	2,427	13,981		9
10	Nursing and Medical Records	1,373,188	103,116	4,839	1,481,143		1,481,143		1,481,143		10
10a	Therapy		364,393	390,770	755,163	(388,113)	367,050	262,238	629,288		10a
11	Activities	48,018	1,546		49,564		49,564	1,563	51,127		11
12	Social Services	35,727		2,901	38,628		38,628		38,628		12
13	CNA Training	3,513	2,748		6,261		6,261	1,236	7,497		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,460,446	471,803	410,064	2,342,313	(388,113)	1,954,200	267,464	2,221,664		16
	C. General Administration										
17	Administrative	80,225			80,225		80,225	75,275	155,500		17
18	Directors Fees							8,018	8,018		18
19	Professional Services			192,646	192,646		192,646	(184,477)	8,169		19
20	Dues, Fees, Subscriptions & Promotions			88,710	88,710	(59,130)	29,580	(8,203)	21,377		20
21	Clerical & General Office Expenses	136,742	21,153	8,556	166,451		166,451	168,904	335,355		21
22	Employee Benefits & Payroll Taxes			460,371	460,371		460,371	34,518	494,889		22
23	Inservice Training & Education			3,350	3,350		3,350	(1,351)	1,999		23
24	Travel and Seminar			11,265	11,265		11,265	(9,266)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			51,325	51,325		51,325	12,002	63,327		26
27	Other (specify):*			12,000	12,000		12,000	(12,000)			27
28	TOTAL General Administration	216,967	21,153	828,223	1,066,343	(59,130)	1,007,213	83,420	1,090,633		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,044,336	753,605	1,394,509	4,192,450	(447,243)	3,745,207	373,830	4,119,037		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Manor-Carlinville #0048850 Report Period Beginning: 01/01/08 Ending: 12/31/08

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							158,561	158,561			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,147	16,147		16,147	74,481	90,628			32
33	Real Estate Taxes							42,289	42,289			33
34	Rent-Facility & Grounds			473,040	473,040		473,040	(461,326)	11,714			34
35	Rent-Equipment & Vehicles			8,947	8,947		8,947	1,997	10,944			35
36	Other (specify):*											36
37	TOTAL Ownership			498,134	498,134		498,134	(183,998)	314,136			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					388,113	388,113		388,113			39
40	Barber and Beauty Shops		341	8,347	8,688		8,688		8,688			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					59,130	59,130		59,130			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		341	8,347	8,688	447,243	455,931		455,931			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,044,336	753,946	1,900,990	4,699,272		4,699,272	189,832	4,889,104			45

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

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning: 01/01/08

Ending: 12/31/08

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(2,622)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)	(2,088)	23		16
17	Non-Care Related Fees	(1,376)	20		17
18	Fines and Penalties				18
19	Entertainment	(20,074)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,045)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(14,095)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,300)		\$	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)	245,132		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 245,132		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 189,832		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Carlinville

ID# 0048850

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16		(2,088)	23
17		(1,376)	20
18			18
19			24
20		0	27
21			21
22		(3,045)	19
23			23
24		(12,000)	27
25		(14,095)	20
26			26
27			27
28			28
29		0	33
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(32,604)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	5,945	0	0	0	0	0	0	0	0	5,945	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	22	0	0	0	0	0	0	0	0	22	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,092	0	0	0	0	0	0	0	0	2,092	5
6	Maintenance	0	0	14,887	0	0	0	0	0	0	0	0	14,887	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	22,946	0	0	0	0	0	0	0	0	22,946	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,427	0	0	0	0	0	0	0	0	2,427	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	262,238	0	0	0	0	0	0	0	0	0	262,238	10a
11	Activities	0	0	1,563	0	0	0	0	0	0	0	0	1,563	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,236	0	0	0	0	0	0	0	0	1,236	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	262,238	5,226	0	0	0	0	0	0	0	0	267,464	16
	C. General Administration													
17	Administrative	0	0	75,275	0	0	0	0	0	0	0	0	75,275	17
18	Directors Fees	0	0	8,018	0	0	0	0	0	0	0	0	8,018	18
19	Professional Services	(3,045)	(189,601)	8,169	0	0	0	0	0	0	0	0	(184,477)	19
20	Fees, Subscriptions & Promotions	(15,471)	0	7,268	0	0	0	0	0	0	0	0	(8,203)	20
21	Clerical & General Office Expenses	0	0	168,904	0	0	0	0	0	0	0	0	168,904	21
22	Employee Benefits & Payroll Taxes	0	0	34,518	0	0	0	0	0	0	0	0	34,518	22
23	Inservice Training & Education	(2,088)	0	737	0	0	0	0	0	0	0	0	(1,351)	23
24	Travel and Seminar	(20,074)	0	10,808	0	0	0	0	0	0	0	0	(9,266)	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	12,002	0	0	0	0	0	0	0	0	12,002	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	TOTAL General Administration	(52,678)	(189,601)	325,699	0	0	0	0	0	0	0	0	83,420	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,678)	72,637	353,871	0	0	0	0	0	0	0	0	373,830	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning:

01/01/08 Ending:

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	147,021	0	11,540	0	0	0	0	0	0	0	158,561	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,622)	70,159	0	6,944	0	0	0	0	0	0	0	74,481	32
33	Real Estate Taxes	0	42,289	0	0	0	0	0	0	0	0	0	42,289	33
34	Rent-Facility & Grounds	0	(473,040)	0	11,714	0	0	0	0	0	0	0	(461,326)	34
35	Rent-Equipment & Vehicles	0	0	0	1,997	0	0	0	0	0	0	0	1,997	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,622)	(213,571)	0	32,195	0	(183,998)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(55,300)	(140,934)	353,871	32,195	0	189,832	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
See Attached						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
1	V		\$			\$	1
2	V	10a Adjustment for Related Organization		GreenTree Pharmacy		262,238	262,238 2
3	V						3
4	V	19 Adjustment for Related Organization	189,601	Heritage Operations Group, LLC	0.00%		(189,601) 4
5	V						5
6	V	34 Adjustment for Related Organization	473,040	Heritage Manor Real Estate, LLC	0.00%		(473,040) 6
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		42,289	42,289 7
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		55,364	55,364 8
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		147,021	147,021 9
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		14,795	14,795 10
11	V						11
12	V						12
13	V						13
14	Total		\$ 662,641			\$ 521,707	\$ * (140,934) 14

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

Facility Name & ID Number Heritage Manor-Carlinville# 0048850Report Period Beginning: 01/01/08Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$ 5,945	\$ 5,945	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				22	22	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				2,092	2,092	19
20	V	6 Maintenance				14,887	14,887	20
21	V	7 Other				0		21
22	V	9 Medical Director				2,427	2,427	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,563	1,563	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				1,236	1,236	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				75,275	75,275	29
30	V	18 Directors Fees				8,018	8,018	30
31	V	19 Professional Services				8,169	8,169	31
32	V	20 Fees, Subscription, Promotions				7,268	7,268	32
33	V	21 Clerical & General Office Expenses				168,904	168,904	33
34	V	22 Employee Benefits & Payroll Taxes				34,518	34,518	34
35	V	23 Inservice Training & Education				737	737	35
36	V	24 Travel and Seminar				10,808	10,808	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				12,002	12,002	38
39	Total		\$			\$ 353,871	\$ * 353,871	39

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

Facility Name & ID Number Heritage Manor-Carlinville# 0048850Report Period Beginning: 01/01/08Ending: 12/31/08**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$		0.00%	\$ 0	\$	15
16	V	30 Depreciation				11,540		11,540 16
17	V	31 Amortization of Pre-Op & Org				0		0 17
18	V	32 Interest				6,944		6,944 18
19	V	33 Real Estate Taxes				0		0 19
20	V	34 Rent-Facility & Grounds				11,714		11,714 20
21	V	35 Rent-Equipment & Vehicles				1,997		1,997 21
22	V	36 Other				0		0 22
23	V	38 Medically Nec Transportation				0		0 23
24	V	39 Ancillary Service Centers				0		0 24
25	V	40 Barber and Beauty Shops				0		0 25
26	V	41 Coffee and Gift Shops				0		0 26
27	V	42 Other				0		0 27
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$ 32,195	\$ *	32,195 39

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					\$ 8,018	18/7	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	\$ 8,018		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning: 01/01/08

Ending: 12/31/08

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 Heritage Operations Group
 Street Address box 3188
 City / State / Zip Code Bloomington, IL 61701
 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	Dietary	Beds	2,634	25	\$ 144,981	\$ 144,706	108	\$ 5,945	1
2	2	Food Purchase	Beds	2,634	25	0	0	108	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	108	22	3
4	4	Laundry	Beds	2,634	25	0	0	108	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	108	2,092	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	108	14,887	6
7	7	Other	Beds	2,634	25	0	0	108	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	108	2,427	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	108	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	108	1,563	10
11	12	Social Service	Beds	2,634	25	0	0	108	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	108	1,236	12
13	14	Program Transportation	Beds	2,634	25	0	0	108	0	13
14	15	Other	Beds	2,634	25	0	0	108	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	108	75,275	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	108	8,018	16
17	19	Professional Services	Beds	2,634	25	199,226	0	108	8,169	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	108	7,268	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	108	168,904	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	108	34,518	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	108	737	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	108	10,808	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	108	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	108	12,002	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 353,871	25

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	27	Other	Beds	2,634	108	\$	\$	108	\$	1
2	30	Depreciation	Beds	2,634	108	281,453		108	11,540	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	108			108		3
4	32	Interest	Beds	2,634	108	169,367		108	6,944	4
5	33	Real Estate Taxes	Beds	2,634	108			108		5
6	34	Rent-Facility & Grounds	Beds	2,634	108	285,687		108	11,714	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	108	48,715		108	1,997	7
8	36	Other	Beds	2,634	108			108		8
9	38	Medically Nec Transportation	Beds	2,634	108			108		9
10	39	Ancillary Service Centers	Beds	2,634	108			108		10
11	40	Barber and Beauty Shops	Beds	2,634	108			108		11
12	41	Coffee and Gift Shops	Beds	2,634	108			108		12
13	42	Other	Beds	2,634	108			108		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					\$ 785,222	\$		\$ 32,195	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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		xx	Mortgage			\$	\$ 869,661	03/11	variable	\$ 52,610	1
2	Bank of America		xx	Loan Fees							14,795	2
3	Alpha Bank		xx	Van				33,023		5.5000	2,754	3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							16,147	6
7												7
8												8
9	TOTAL Facility Related						\$	\$ 902,684			\$ 86,306	9
	B. Non-Facility Related*											
10	Interest Income										(2,622)	10
11	Allocated Corporate										6,944	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 4,322	14
15	TOTALS (line 9+line14)						\$	\$ 902,684			\$ 90,628	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none 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 2007 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.)			\$ 42,289	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 42,289	3
4. Real Estate Tax accrual used for 2008 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.			\$ 42,289	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	32,706	8		
2004	35,898	9		
2005	38,496	10		
2006	40,216	11		
2007	42,289	12		
			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2007	\$		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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Carlinville COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0048850

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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-000-264-02</u>	_____	\$ <u>42,289.00</u>	\$ <u>42,289.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>42,289.00</u>	\$ <u>42,289.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Heritage Manor-Carlinville

0048850 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,527 B. General Construction Type: Exterior brick Frame wood Number of Stories _____

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

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

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

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

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

none

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>32,017</u>	1
2					2
3	TOTALS			\$ <u>32,017</u>	3

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	108				\$ 3,265,145	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Heritage Manor Sign		1996	2,176						9
10		Architect Fees		1996	2,387						10
11		Laundry Room Electrical Repair		1996	3,019						11
12											12
13											13
14		Special Care Unit -- Remodel		1997	30,884						14
15											15
16		Remodel-- Alzheimer Wing		1998	78,813						16
17		A/C Unit		1998	950						17
18		Life Safety Improvements		1998	7,351						18
19		Shower Room Remodel		1998	2,811						19
20		Roof Replacement		1998	92,246						20
21											21
22		Door Alarm		1999	2,317						22
23		Smoke Damperer		1999	498						23
24		Water System		1999	8,115						24
25		Interior Painting--Material and Labor		1999	6,892						25
26		Shower Room Remodel		1999	2,453						26
27		Water Heater		1999	4,253						27
28											28
29											29
30											30
31											31
32											32
33											33
34		C/O Allocation						11,540	11,540		34
35		Book Depreciation				108,953		108,953		1,179,001	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	Water Softener	2000	\$ 3,802	\$		\$	\$	\$	37
38	Shower room Remodel ---Material and Labor	2000	3,608						38
39	A/C Rooftop Unit	2000	12,490						39
40	Pipe --Hallway Floor	2000	1,920						40
41									41
42	Electric Heater	2001	4,700						42
43									43
44	A/C Rooftop Unit-(remove)	2002	(12,490)						44
45	Heat / Cool Unit	2002	8,969						45
46	Floor Coverings	2002	6,638						46
47	Roof top unit	2002	4,995						47
48	Roof top unit	2002	2,918						48
49									49
50	Floor coverings	2003	11,232						50
51	Resurface parking lot	2003	25,786						51
52	A/C unit	2003	11,167						52
53	Dishwasher	2003	3,880						53
54	Boiler	2003	1,978						54
55	Backflow unit	2003	740						55
56	Heat / Cool Unit	2003	5,607						56
57									57
58	Hot Water Pump	2004	750						58
59	Heat / Cool Unit	2004	4,485						59
60	Booster Heater	2004	2,261						60
61	Door Closer	2004	578						61
62	A/C Unit	2004	1,101						62
63	Roof top unit	2004	3,504						63
64	Electric Heater	2004	13,454						64
65	Secure Care System	2004	3,053						65
66	Ansul System	2004	1,685						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,639,121	\$ 108,953		\$ 120,493	\$ 11,540	\$ 1,179,001	70

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

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning:

01/01/08

Ending:

12/31/08

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		\$ 3,639,121	\$ 108,953		\$ 120,493	\$ 11,540	\$ 1,179,001	1
2	Window Replacement	2005	371						2
3	HVAC	2005	10,165						3
4	Rooftop A/C	2005	8,997						4
5	Water Storage Tank	2005	4,456						5
6	Rooftop Heater	2005	3,425						6
7									7
8	Sidewalk	2006	630						8
9	Parking Lot Sealer	2006	2,385						9
10	Window Replacement	2006	1,638						10
11	Resident room remodel -- paint, wall coverings	2006	9,197						11
12	Smoke detectors	2006	1,644						12
13									13
14	Resident room remodel -- paint, wall coverings	2007	4,459						14
15	Corridor Rehab -- Paint/Wallpaper	2007	23,721						15
16	HVAC	2007	9,819						16
17	Fire Alarm	2007	2,900						17
18	Rosedale Corridor Rehab-- Paint/ Wallpaper	2007	5,027						18
19	Sprinkler System	2007	3,398						19
20	Heat Detector	2007	2,091						20
21	Landscaping	2007	4,999						21
22	Rosedale Resident room Rehab -- Paint/Wallpaper	2007	32,026						22
23	Rooftop A/C	2007	4,417						23
24	Kitchen Repairs	2007	2,512						24
25	Asbestos Sample	2007	545						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,777,943	\$ 108,953		\$ 120,493	\$ 11,540	\$ 1,179,001	34

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

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 3,777,943	\$ 108,953		\$ 120,493	\$ 11,540	\$ 1,179,001		1
2	PTAC Units	2008 7,980							2
3	Nurse call/Phone System	2008 157,428							3
4	Kitchen Water Heater	2008 2,600							4
5	Rosedale wing room remodel-- paint/flooring	2008 19,311							5
6	Kitchen plumbing	2008 3,130							6
7	Sprinkler	2008 5,972							7
8	Legacy Unit Remodel--paint/flooring	2008 37,161							8
9	Fire Alarm	2008 47,279							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)	\$ 4,058,804	\$ 108,953		\$ 120,493	\$ 11,540	\$ 1,179,001		34

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

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,058,804	\$ 108,953		\$ 120,493	\$ 11,540	\$ 1,179,001	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,058,804	\$ 108,953		\$ 120,493	\$ 11,540	\$ 1,179,001	34

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

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 567,843	\$ 38,068	\$ 38,068	\$		\$ 443,012	71
72	Current Year Purchases	71,715						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 639,558	\$ 38,068	\$ 38,068	\$		\$ 443,012	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)	\$ 4,730,379	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 147,021	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 158,561	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,540	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,622,013	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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 8,947 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		2,748		2,748
3	Classroom Wages (a)				
4	Clinical Wages (b)		3,513		3,513
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,261	\$	\$ 6,261
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,261		

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Heritage Manor-Carlinville# 0048850

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 169,092	\$		\$ 169,092	1
2	Licensed Speech and Language Development Therapist		hrs			23,608			23,608	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			173,291	1,059		174,350	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				363,334		363,334	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					24,779			24,779	13
14	TOTAL			\$		\$ 390,770	\$ 364,393		\$ 755,163	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Manor-Carlinville # 0048850 Report Period Beginning: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (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	\$ 432	\$	1
2	Cash-Patient Deposits	11,372		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	610,126		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,134		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,843,126)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,205,062)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (1,205,062)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 129,431	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,372		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	166,868		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,015		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	<u>IPA Tax</u>	14,904		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 346,590	\$	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 346,590	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,551,652)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,205,062)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,368,276)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,368,276)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(183,376)	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)	\$ (183,376)	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)	\$ (1,551,652)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Carlinville# 0048850Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 4,297,829	1
2	Discounts and Allowances for all Levels	(1,825,231)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,472,598	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,365,935	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,365,935	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	981	12
13	Barber and Beauty Care	11,524	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	650,454	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,782	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 674,741	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,622	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,622	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,515,896	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	783,794	31
32	Health Care	2,342,313	32
33	General Administration	1,066,343	33
B. Capital Expense			
34	Ownership	498,134	34
C. Ancillary Expense			
35	Special Cost Centers	8,688	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,699,272	40
41	Income before Income Taxes (line 30 minus line 40)**	(183,376)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (183,376)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor-Carlinville

0048850

Report Period Beginning: 01/01/08

Ending:

12/31/08

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	1,872	2,068	\$ 46,407	\$ 22.44	1
2	Assistant Director of Nursing	1,642	1,680	34,477	20.52	2
3	Registered Nurses	2,880	5,166	74,388	14.40	3
4	Licensed Practical Nurses	18,847	20,059	442,544	22.06	4
5	CNAs & Orderlies	68,051	73,154	747,549	10.22	5
6	CNA Trainees	350	350	3,513	10.04	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,920	2,087	27,823	13.33	8
9	Activity Director					9
10	Activity Assistants	5,117	5,430	48,018	8.84	10
11	Social Service Workers	2,467	2,631	35,727	13.58	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,418	18,382	171,827	9.35	15
16	Dishwashers					16
17	Maintenance Workers	4,154	4,485	50,605	11.28	17
18	Housekeepers	11,075	11,370	96,776	8.51	18
19	Laundry	1,783	1,992	47,715	23.95	19
20	Administrator	1,900	2,080	80,225	38.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,443	9,348	136,742	14.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,919	160,282	\$ 2,044,336 *	\$ 12.75	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		11,554		36
37	Medical Records Consultant		1,294		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,240		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,901		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 18,989		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		0		52
53	TOTAL (lines 50 - 52)		\$		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES x NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Heritage Manor Carlinville 41509 07/2007
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 59,130
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 845
- (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. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
- g. Does the facility transport residents to and from day training? no**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. Not available at this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

Item	Code	Unit	Quantity	Price	Total	Description
1	101	kg	100	1.00	100.00	101
2	102	kg	100	1.00	100.00	102
3	103	kg	100	1.00	100.00	103
4	104	kg	100	1.00	100.00	104
5	105	kg	100	1.00	100.00	105
6	106	kg	100	1.00	100.00	106
7	107	kg	100	1.00	100.00	107
8	108	kg	100	1.00	100.00	108
9	109	kg	100	1.00	100.00	109
10	110	kg	100	1.00	100.00	110
11	111	kg	100	1.00	100.00	111
12	112	kg	100	1.00	100.00	112
13	113	kg	100	1.00	100.00	113
14	114	kg	100	1.00	100.00	114
15	115	kg	100	1.00	100.00	115
16	116	kg	100	1.00	100.00	116
17	117	kg	100	1.00	100.00	117
18	118	kg	100	1.00	100.00	118
19	119	kg	100	1.00	100.00	119
20	120	kg	100	1.00	100.00	120
21	121	kg	100	1.00	100.00	121
22	122	kg	100	1.00	100.00	122
23	123	kg	100	1.00	100.00	123
24	124	kg	100	1.00	100.00	124
25	125	kg	100	1.00	100.00	125
26	126	kg	100	1.00	100.00	126
27	127	kg	100	1.00	100.00	127
28	128	kg	100	1.00	100.00	128
29	129	kg	100	1.00	100.00	129
30	130	kg	100	1.00	100.00	130
31	131	kg	100	1.00	100.00	131
32	132	kg	100	1.00	100.00	132
33	133	kg	100	1.00	100.00	133
34	134	kg	100	1.00	100.00	134
35	135	kg	100	1.00	100.00	135
36	136	kg	100	1.00	100.00	136
37	137	kg	100	1.00	100.00	137
38	138	kg	100	1.00	100.00	138
39	139	kg	100	1.00	100.00	139
40	140	kg	100	1.00	100.00	140
41	141	kg	100	1.00	100.00	141
42	142	kg	100	1.00	100.00	142
43	143	kg	100	1.00	100.00	143
44	144	kg	100	1.00	100.00	144
45	145	kg	100	1.00	100.00	145
46	146	kg	100	1.00	100.00	146
47	147	kg	100	1.00	100.00	147
48	148	kg	100	1.00	100.00	148
49	149	kg	100	1.00	100.00	149
50	150	kg	100	1.00	100.00	150
51	151	kg	100	1.00	100.00	151
52	152	kg	100	1.00	100.00	152
53	153	kg	100	1.00	100.00	153
54	154	kg	100	1.00	100.00	154
55	155	kg	100	1.00	100.00	155
56	156	kg	100	1.00	100.00	156
57	157	kg	100	1.00	100.00	157
58	158	kg	100	1.00	100.00	158
59	159	kg	100	1.00	100.00	159
60	160	kg	100	1.00	100.00	160
61	161	kg	100	1.00	100.00	161
62	162	kg	100	1.00	100.00	162
63	163	kg	100	1.00	100.00	163
64	164	kg	100	1.00	100.00	164
65	165	kg	100	1.00	100.00	165
66	166	kg	100	1.00	100.00	166
67	167	kg	100	1.00	100.00	167
68	168	kg	100	1.00	100.00	168
69	169	kg	100	1.00	100.00	169
70	170	kg	100	1.00	100.00	170
71	171	kg	100	1.00	100.00	171
72	172	kg	100	1.00	100.00	172
73	173	kg	100	1.00	100.00	173
74	174	kg	100	1.00	100.00	174
75	175	kg	100	1.00	100.00	175
76	176	kg	100	1.00	100.00	176
77	177	kg	100	1.00	100.00	177
78	178	kg	100	1.00	100.00	178
79	179	kg	100	1.00	100.00	179
80	180	kg	100	1.00	100.00	180
81	181	kg	100	1.00	100.00	181
82	182	kg	100	1.00	100.00	182
83	183	kg	100	1.00	100.00	183
84	184	kg	100	1.00	100.00	184
85	185	kg	100	1.00	100.00	185
86	186	kg	100	1.00	100.00	186
87	187	kg	100	1.00	100.00	187
88	188	kg	100	1.00	100.00	188
89	189	kg	100	1.00	100.00	189
90	190	kg	100	1.00	100.00	190
91	191	kg	100	1.00	100.00	191
92	192	kg	100	1.00	100.00	192
93	193	kg	100	1.00	100.00	193
94	194	kg	100	1.00	100.00	194
95	195	kg	100	1.00	100.00	195
96	196	kg	100	1.00	100.00	196
97	197	kg	100	1.00	100.00	197
98	198	kg	100	1.00	100.00	198
99	199	kg	100	1.00	100.00	199
100	200	kg	100	1.00	100.00	200

Item	Code	Unit	Quantity	Price	Total	Description
101	101	kg	100	1.00	100.00	101
102	102	kg	100	1.00	100.00	102
103	103	kg	100	1.00	100.00	103
104	104	kg	100	1.00	100.00	104
105	105	kg	100	1.00	100.00	105
106	106	kg	100	1.00	100.00	106
107	107	kg	100	1.00	100.00	107
108	108	kg	100	1.00	100.00	108
109	109	kg	100	1.00	100.00	109
110	110	kg	100	1.00	100.00	110
111	111	kg	100	1.00	100.00	111
112	112	kg	100	1.00	100.00	112
113	113	kg	100	1.00	100.00	113
114	114	kg	100	1.00	100.00	114
115	115	kg	100	1.00	100.00	115
116	116	kg	100	1.00	100.00	116
117	117	kg	100	1.00	100.00	117
118	118	kg	100	1.00	100.00	118
119	119	kg	100	1.00	100.00	119
120	120	kg	100	1.00	100.00	120
121	121	kg	100	1.00	100.00	121
122	122	kg	100	1.00	100.00	122
123	123	kg	100	1.00	100.00	123
124	124	kg	100	1.00	100.00	124
125	125	kg	100	1.00	100.00	125
126	126	kg	100	1.00	100.00	126
127	127	kg	100	1.00	100.00	127
128	128	kg	100	1.00	100.00	128
129	129	kg	100	1.00	100.00	129
130	130	kg	100	1.00	100.00	130
131	131	kg	100	1.00	100.00	131
132	132	kg	100	1.00	100.00	132
133	133	kg	100	1.00	100.00	133
134	134	kg	100	1.00	100.00	134
135	135	kg	100	1.00	100.00	135
136	136	kg	100	1.00	100.00	136
137	137	kg	100	1.00	100.00	137
138	138	kg	100	1.00	100.00	138
139	139	kg	100	1.00	100.00	139
140	140	kg	100	1.00	100.00	140
141	141	kg	100	1.00	100.00	141
142	142	kg	100	1.00	100.00	142
143	143	kg	100	1.00	100.00	143
144	144	kg	100	1.00	100.00	144
145	145	kg	100	1.00	100.00	145
146	146	kg	100	1.00	100.00	146
147	147	kg	100	1.00	100.00	147
148	148	kg	100	1.00	100.00	148
149	149	kg	100	1.00	100.00	149
150	150	kg	100	1.00	100.00	150
151	151	kg	100	1.00	100.00	151
152	152	kg	100	1.00	100.00	152
153	153	kg	100	1.00	100.00	153
154	154	kg	100	1.00	100.00	154
155	155	kg	100	1.00	100.00	155
156	156	kg	100	1.00	100.00	156
157	157	kg	100	1.00	100.00	157
158	158	kg	100	1.00	100.00	158
159	159	kg	100	1.00	100.00	159
160	160	kg	100	1.00	100.00	160
161	161	kg	100	1.00	100.00	161
162	162	kg	100	1.00	100.00	162
163	163	kg	100	1.00	100.00	163
164	164	kg	100	1.00	100.00	164
165	165	kg	100	1.00	100.00	165
166	166	kg	100	1.00	100.00	166
167	167	kg	100	1.00	100.00	167
168	168	kg	100	1.00	100.00	168
169	169	kg	100	1.00	100.00	169
170	170	kg	100	1.00	100.00	170
171	171	kg	100	1.00	100.00	171
172	172	kg	100	1.00	100.00	172
173	173	kg	100	1.00	100.00	173
174	174	kg	100	1.00	100.00	174
175	175	kg	100	1.00	100.00	175
176	176	kg	100	1.00	100.00	176
177	177	kg	100	1.00	100.00	177
178	178	kg	100	1.00	100.00	178
179	179	kg	100	1.00	100.00	179
180	180	kg	100	1.00	100.00	180
181	181	kg	100	1.00	100.00	181
182	182	kg	100	1.00	100.00	182
183	183	kg	100	1.00	100.00	183
184	184	kg	100	1.00	100.00	184
185	185	kg	100	1.00	100.00	185
186	186	kg	100	1.00	100.00	186
187	187	kg	100	1.00	100.00	187
188	188	kg	100	1.00	100.00	188
189	189	kg	100	1.00	100.00	189
190	190	kg	100	1.00	100.00	190
191	191	kg	100	1.00	100.00	191
192	192	kg	100	1.00	100.00	192
193	193	kg	100	1.00	100.00	193
194	194	kg	100	1.00	100.00	194
195	195	kg	100	1.00	100.00	195

