

Facility Name & ID Number Heartland Manor Nursing Center

0002923 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	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	653	847	2,556	4,056	8
9	SNF/PED					9
10	ICF	11,934	9,297		21,231	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,587	10,144	2,556	25,287	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.98%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Meals on Wheels

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

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

YES NO

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

Date started 12/18/1964

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

YES Date N/A NO

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

YES NO If YES, enter number of beds certified 28 and days of care provided 2,556

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/06 Fiscal Year: 06/30/06

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	214,671	14,722	5,270	234,663		234,663		234,663		1
2	Food Purchase		124,525		124,525		124,525	(11,008)	113,517		2
3	Housekeeping	98,847	15,518	662	115,027		115,027	(17,600)	97,427		3
4	Laundry	72,326	16,675	267	89,268		89,268		89,268		4
5	Heat and Other Utilities			102,410	102,410		102,410		102,410		5
6	Maintenance	45,180	4,533	26,438	76,151		76,151		76,151		6
7	Other (specify):* Waste Removal			5,334	5,334		5,334		5,334		7
8	TOTAL General Services	431,024	175,973	140,381	747,378		747,378	(28,608)	718,770		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,181,465	114,300	59,113	1,354,878		1,354,878		1,354,878		10
10a	Therapy			214,975	214,975		214,975		214,975		10a
11	Activities	60,549	4,474	1,974	66,997		66,997		66,997		11
12	Social Services	10,545		1,974	12,519		12,519		12,519		12
13	CNA Training			1,750	1,750		1,750		1,750		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,252,559	118,774	285,786	1,657,119		1,657,119		1,657,119		16
	C. General Administration										
17	Administrative	100,219			100,219		100,219		100,219		17
18	Directors Fees										18
19	Professional Services			63,373	63,373		63,373		63,373		19
20	Dues, Fees, Subscriptions & Promotions			16,425	16,425		16,425	(598)	15,827		20
21	Clerical & General Office Expenses	111,928	10,140	26,683	148,751		148,751	(10,735)	138,016		21
22	Employee Benefits & Payroll Taxes			365,575	365,575		365,575		365,575		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,115	6,115		6,115	(30)	6,085		24
25	Other Admin. Staff Transportation			809	809		809		809		25
26	Insurance-Prop.Liab.Malpractice			59,989	59,989		59,989		59,989		26
27	Other (specify):*										27
28	TOTAL General Administration	212,147	10,140	538,969	761,256		761,256	(11,363)	749,893		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,895,730	304,887	965,136	3,165,753		3,165,753	(39,971)	3,125,782		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

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

Facility Name & ID Number Heartland Manor Nursing Center

#0002923

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			99,727	99,727		99,727	(3,643)	96,084			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,594	9,594		9,594	(1,009)	8,585			32
33	Real Estate Taxes			3,642	3,642		3,642	(3,642)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			112,963	112,963		112,963	(8,294)	104,669			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	17,503	52,147		69,650		69,650		69,650			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* Nonallowable Cost			141,761	141,761		141,761	(141,761)				43
44	TOTAL Special Cost Centers	17,503	52,147	195,964	265,614		265,614	(141,761)	123,853			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,913,233	357,034	1,274,063	3,544,330		3,544,330	(190,026)	3,354,304			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	OHF 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	(1,509)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,643)	30		9
10	Interest and Other Investment Income	(124)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(885)	32		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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 See pg. 5A	(183,865)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (190,026)		\$	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))	\$ (190,026)		37

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

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

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

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Heartland Manor Nursing Center

ID# 0002923

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Bad Debts	\$ (92,715)	43	1
2	Disallow Medicare Part A - Lab	(1,921)	43	2
3	Disallow Medicare Part A - X-Ray	(1,711)	43	3
4	Disallow Promotional Advertising	(33,051)	43	4
5	Disallow Medicare Part A - Other	(3,089)	43	5
6	Disallow Gain/Loss on Sale of Assets	(7,765)	43	6
7	Disallow Real Estate Taxes on Non-Care Assets	(3,642)	33	7
8	Disallow nonallowable Civil Penalty from CMS	(7,140)	21	8
9	Disallow replacement cost for lost resident property	(3,595)	21	9
10	Disallow nonallowable Dues	(598)	20	10
11	Offset food income against related expense	(11,008)	2	11
12	Offset housekeeping income against related expense	(17,600)	3	12
13	Disallow non-allowable travel & seminar	(30)	24	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	(183,865)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Manor Nursing Center# 0002923

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,008)	0	0	0	0	0	0	0	0	0	0	(11,008)	2
3	Housekeeping	(17,600)	0	0	0	0	0	0	0	0	0	0	(17,600)	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	(28,608)	0	(28,608)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(598)	0	0	0	0	0	0	0	0	0	0	(598)	20
21	Clerical & General Office Expenses	(10,735)	0	0	0	0	0	0	0	0	0	0	(10,735)	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	(30)	0	0	0	0	0	0	0	0	0	0	(30)	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	(11,363)	0	(11,363)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(39,971)	0	(39,971)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Manor Nursing Center# 0002923

Report Period Beginning:

07/01/2005 Ending:06/30/2006

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(3,643)	0	0	0	0	0	0	0	0	0	0	(3,643) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(1,009)	0	0	0	0	0	0	0	0	0	0	(1,009) 32
33	Real Estate Taxes	(3,642)	0	0	0	0	0	0	0	0	0	0	(3,642) 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	(8,294)	0	0	0	0	0	0	0	0	0	0	(8,294) 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):*	(141,761)	0	0	0	0	0	0	0	0	0	0	(141,761) 43
44	TOTAL Special Cost Centers	(141,761)	0	0	0	0	0	0	0	0	0	0	(141,761) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(190,026)	0	0	0	0	0	0	0	0	0	0	(190,026) 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 schedule 6A		N/A		N/A		

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		\$	N/A		\$	\$	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.

Heartland Manor Nursing Center
Facility ID: 0002923
Year End: 06/30/2006

Schedule 6A

Board of Directors

Marilyn Resch

Ted Perillo

Dr. Pat Niebrugge

David Belt

Linda Fahy

Ginny Collins

Marcia Vidoni

Position

President

Vice-President

Secretary

Member

Member

Member

Member

Services Rendered to the Facility

Member of Parker, Siemer, Austin Resch & Fuhr - Provided minimal legal services

Owner of The Pharmacie Shoppe - Provided pharmacy services

No services provided

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/2005 Ending: 06/30/2006

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		N/A								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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2005

Ending: 6/30/2006

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 N/A

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					\$	\$		\$	1
2	N/A								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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Leasehold obligations		X	Time clock	\$132.00	12/2002	\$ 6,915	\$ 1,869	11/2007	0.0382	\$ 102	1						
2	Leasehold obligations		X	Electric bed	\$1,277.00	03/2004	38,225	11,498	02/2007	0.1204	1,757	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Regents Bank		X	Working capital	None	2/2005	250,000	42,906	Demand	0.0475	6,851	6						
7												7						
8	Various		X	Finance charges & late payment fees							884	8						
9	TOTAL Facility Related				\$1,409.00		\$ 295,140	\$ 56,273			\$ 9,594	9						
B. Non-Facility Related*																		
10											(125)	10						
11											(884)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (1,009)	14						
15	TOTALS (line 9+line14)						\$ 295,140	\$ 56,273			\$ 8,585	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 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.)

\$ **N/A** **2**

3. Under or (over) accrual (line 2 minus line 1).

\$ **3**

4. Real Estate Tax accrual used for 2006 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:	2001	<u> </u>	8
	2002	<u> </u>	9
	2003	<u> </u>	10
	2004	<u> </u>	11
	2005	<u> </u>	12

Facility is a not-for-profit entity and is exempt from real estate taxes.

Real estate tax is paid on non-care assets; however, the tax is adjusted out of the cost report per instructions.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$ <u> </u>	13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u>	14
15	LESS REFUND FROM LINE 6	\$ <u> </u>	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u>	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Manor Nursing Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0002923

CONTACT PERSON REGARDING THIS REPORT David J. Sauer

TELEPHONE 217-932-4081 FAX #: 217-932-4922

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. Facility pays real estate taxes on non-care assets. All costs are adjusted		\$ _____	\$ _____
2. out of the cost report		\$ _____	\$ _____
3. _____		\$ _____	\$ _____
4. <u>03-11-19-08-203-046</u>	<u>Lots 8&9 Sturdevant & Goble Addn</u>	\$ <u>1,202.00</u>	\$ <u>None</u>
5. <u>03-11-19-08-203-047</u>	<u>Lots 4&5 Sturdevant & Goble Addn</u>	\$ <u>1,368.84</u>	\$ <u>None</u>
6. <u>03-11-19-08-203-049</u>	<u>Lot 2 Sturdevant & Goble Addn</u>	\$ <u>1,493.76</u>	\$ <u>None</u>
7. <u>03-11-19-08-203-050</u>	<u>Lot 3&6 Sturdevand & Goble Addn.</u>	\$ <u>1,961.42</u>	\$ <u>None</u>
8. Attached real estate bills are for 2006 taxes payable in 2005.		\$ _____	\$ <u>None</u>
9. 6/30/06, facility payments included on this cost report are for 2005		\$ _____	\$ _____
10. taxes paid in calendar 2006.		\$ _____	\$ _____
TOTALS		\$ <u>6,026.02</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? See Above 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2005 Ending:

06/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,047 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>152,472</u>	<u>1964</u>	<u>\$ 24,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	152,472		\$ 24,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	78	1964	1964	\$ 385,838	\$	25	\$	\$	\$ 385,838	4
5		1966	1966	10,387		25			10,387	5
6		1970	1970	3,400		25			3,400	6
7		1972	1972	11,798		25			11,798	7
8	21	1996	1996	828,949	20,724	40	20,724		207,241	8
Improvement Type**										
9	Building improvements		1973	7,123		10			7,123	9
10	Building improvements		1974	28,947		14-30			28,947	10
11	Building improvements (less disposition of \$1,773 in 2005-06)		1975	5,291		10-30			5,291	11
12	Building improvements		1976	1,607	28	10-30	28		1,522	12
13	Building improvements		1977	1,808		7			1,808	13
14	Building improvements		1978	6,161		5-15			6,161	14
15	Building improvements		1979	949		10			949	15
16	Building improvements		1980	5,829		7			5,829	16
17	Building improvements		1981	1,376		7			1,376	17
18	Building improvements		1982	11,926		3-30			11,926	18
19	Building improvements		1983	6,263		5			6,263	19
20	Building improvements (less disposition of \$1,974 in 2004-05)		1984	16,740		5-15			16,740	20
21	Building improvements (less disposition of \$480 in 2005-06)		1985	5,320		5-15			5,320	21
22	Building improvements (less disposition of \$28,007 in 2005-06)		1986	17,785		10-20			17,785	22
23	Building improvements		1987	27,687		5-15			27,687	23
24	Building improvements		1988	4,282		12-15			4,282	24
25	Building improvements		1989	2,869		15			2,869	25
26										26
27	Building improvements (less disposition of \$2,795 in 2002-03)		1991	631		10			631	27
28	Heating/air system		1992	80,277	4,014	20	4,014		60,878	28
29	Building improvements		1992	3,084		10			3,084	29
30	Building improvements		1992	2,168		10			2,168	30
31										31
32	Building improvements		1992	647		10			647	32
33	Building improvements		1992	4,263	284	15	284		3,907	33
34	Ceiling/floor		1992	49,925	2,496	20	2,496		33,391	34
35	Sprinkler system		1992	60,121	3,006	20	3,006		41,083	35
36	Storage shelving		1993	4,090		10			4,090	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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	Storage shelving	1993	\$ 1,003	\$	10	\$	\$	\$ 1,003	37
38	Resident security system	1993	3,909	195	20	195		2,621	38
39	Cabinets	1993	42,611	2,311	15-20	2,311		28,804	39
40	Heating/air/tubs	1993	29,226	1,461	20	1,461		18,266	40
41	Fire alarm system	1993	12,350	618	20	618		9,213	41
42	Plumbing and water system	1993	8,684	434	20	434		5,752	42
43	Cubicle tracking	1993	1,768		10			1,768	43
44	Building improvements	1994	10,493	517	20	517		6,062	44
45	Building improvements	1995	22,859	2,306	10-20	2,306		19,752	45
46									46
47	Architect fees	1996	74,806	1,870	40	1,870		19,188	47
48	Hvac/insulation/ducts	1996	30,292	757	40	757		7,082	48
49	Sprinklers	1996	9,774	244	40	244		2,196	49
50	Painting	1996	4,052	101	40	101		772	50
51	General contractor fees	1996	7,841	196	40	196		1,764	51
52	Electrical	1996	18,390	460	40	460		3,927	52
53	Chapel work - New Hutton	1996	12,572	629	40	629		6,183	53
54	Cubicle curtain tracking	1996	742	37	20	37		377	54
55	Room signs	1996	3,331	167	20	167		1,667	55
56	Emergency lighting Jones wing	1996	142	7	20	7		74	56
57	Bath systems Jones wing	1996	8,610	431	20	431		4,307	57
58	Sprinklers Jones wing	1996	340	34	10	34		340	58
59	Security locks Jones wing	1996	1,049	52	20	52		523	59
60									60
61	Call lights Jones wing	1996	1,881	94	11	94		940	61
62	Air filtration Jones wing	1996	2,081	104	20	104		1,040	62
63	Wiring-computers & phone	1996	2,970		5			2,970	63
64	Hallway support bars	1996	750	75	10	75		744	64
65	Capitalized interest-new wing	1996	4,700	118	40	118		1,177	65
66	Plumbing	1996	4,640	232	20	232		2,429	66
67	Electrical work (less disposition of \$1,500 in 2005-06)	1996	3,162	233	20	233		1,644	67
68	Flooring	1996	2,400	120	20	120		1,180	68
69	Courtyard	1996	2,766	138	20	138		1,370	69
70	TOTAL (lines 4 thru 69)		\$ 1,927,735	\$ 44,493		\$ 44,493	\$	\$ 1,075,556	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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		\$ 1,927,735	\$ 44,493		\$ 44,493	\$	\$ 1,075,556	1
2	Concrete work entrance	1996	1,470	74	20	74		725	2
3	Building appraisal	1997	2,578	64	40	64		616	3
4	Chapel HVAC	1997	2,324	116	20	116		1,106	4
5	Stained glass window	1997	2,052	103	20	103		951	5
6	Steel door	1997	422	21	20	21		193	6
7	Hot water heater - North Wing	1997	3,838	192	20	192		1,776	7
8									8
9	Hand rails	1997	5,252	263	20	263		2,365	9
10									10
11	Walk in cooler	1997	11,524	576	20	576		5,137	11
12	Fire system work	1997	513	26	20	26		228	12
13	Key pad - security system	1997	360	18	20	18		159	13
14									14
15	Tile flooring - Lobby	1997	900	45	20	45		394	15
16	Hot water heater	1998	7,318	366	20	366		3,111	16
17	Bed light installation	1998	1,826	91	20	91		760	17
18	Hand rails	1998	1,413	71	20	71		587	18
19	Sprinklers	1998	708	35	20	35		291	19
20	Generator bypass switch	1998	1,567	78	20	78		639	20
21									21
22	Lighting - kitchen	1998	985	49	20	49		397	22
23	Paging system	1998	516	26	20	26		205	23
24	Room divider remodeling	1998	391	20	20	20		157	24
25	Bathroom lighting	1998	1,090	55	20	55		429	25
26	South wing remodeling	1998	165	8	20	8		63	26
27	Roof over generator room	1998	568	28	20	28		221	27
28	Bathrooms	1998	7,394	370	20	370		2,866	28
29	Bathrooms-South & Hutton	1998	6,197	310	20	310		2,351	29
30	Fire Alarm System	1999	1,317	66	20	66		478	30
31	Fire & Smoke Dampers	1999	1,664	83	20	83		589	31
32		1999	1,760	88	20	88		631	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,993,847	\$ 47,735		\$ 47,735	\$	\$ 1,102,981	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2005 Ending: 06/30/2006

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		\$ 1,993,847	\$ 47,735		\$ 47,735	\$	\$ 1,102,981	1
2	Generator panel	2000	2,023	202	10	202		1,331	2
3	Gazebo	2000	2,733	273	10	273		1,502	3
4	Anti-scald valves (2)	2001	655	65	10	65		358	4
5	Shower floor replacement	2001	500	25	20	25		138	5
6	Dining room lights	2001	6,013	301	20	301		1,655	6
7									7
8	Toilet stools & seats	2001	1,414	141	10	141		689	8
9	Parking lot asphalt reseal	2001	5,032	251	20	251		1,193	9
10	Ceramic wall tile	2001	365	18	20	18		86	10
11	Washer & nurse call	2001	485	48	10	48		220	11
12	Bath fans	2001	150	15	10	15		69	12
13	Extend legs on links	2001	607	61	10	61		279	13
14	Wallpaper front lobby	2001	150	15	10	15		71	14
15	Remodel North & South showers	2002	2,332	116	20	116		493	15
16	Dorma 7605 EMF-T pullside fire door closers	2002	912	91	10	91		387	16
17	Water heater	2002	4,165	208	20	208		849	17
18									18
19	Compressor - freezer	2002	810	81	10	81		317	19
20	Compressor - kitchen air conditioner	2002	805	54	15	54		202	20
21	Carpet	2003	2,887	144	20	144		450	21
22	Bypass switch for generator	2003	2,166	108	20	108		432	22
23	Sign	2003	850	85	10	85		283	23
24									24
25	Natural Gas Water Heater	2004	3,736	187	20	187		514	25
26	Water Heater	2004	6,548	327	20	327		845	26
27	Wireless Monitoring System	2004	4,263	426	10	426		1,065	27
28	Water heater	2004	3,475	174	20	174		420	28
29	Lights, smoke detectors, other	2004	2,562	256	10	256		576	29
30									30
31	Reconciling items								31
32	Variance in IDPA records & cost report - 1992		26,230						32
33	Variance in IDPA records & cost report - 1993		(22,330)						33
34	TOTAL (lines 1 thru 33)		\$ 2,053,385	\$ 51,407		\$ 51,407	\$	\$ 1,117,405	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,053,385	\$ 51,407		\$ 51,407	\$	\$ 1,117,405	1
2	Security fence (less disposition of \$2,352 in 2005-06)	2005		49	20	49			2
3	Windows - North wing	2005	5,320	266	20	266		510	3
4	Roof air conditioner - dietary	2005	3,997	266	15	266		510	4
5	Windows - South Wing	2005	5,499	275	20	275		481	5
6	Windows - H Wing	2005	4,132	207	20	207		345	6
7	Handrails	2005	1,375	92	15	92		145	7
8	2 ton compressor	2005	558	37	15	37		37	8
9									9
10	Replace tile in driveway	2005	13,100	491	20	491		491	10
11	Generator	2005	20,000	1,000	10	1,000		1,000	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,107,366	\$ 54,090		\$ 54,090	\$	\$ 1,120,924	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning:

07/01/2005

Ending:

06/30/2006

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	\$ 345,097	\$ 43,697	\$ 40,054	\$ (3,643)	5-15	\$ 186,176	71
72	Current Year Purchases	36,792	1,940	1,940		5-20	1,940	72
73	Fully Depreciated Assets	229,173					229,173	73
74								74
75	TOTALS	\$ 611,062	\$ 45,637	\$ 41,994	\$ (3,643)		\$ 417,289	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	Resident Care	1994 Ford Van	1995	\$ 41,610	\$	\$	\$	5	\$ 41,610	76
77										77
78										78
79										79
80	TOTALS			\$ 41,610	\$	\$	\$		\$ 41,610	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,784,038	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,727	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,084	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,643)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,579,823	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	See Schedule 13A attached	187,989	3,459	18,192	88
89					89
90					90
91	TOTALS	\$ 187,989	\$ 3,459	\$ 18,192	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Heartland Manor Nursing Center
 Provider #: 00002923
 7/1/2005 to 6/30/2006

Schedule 13A

XI. Ownership CostsSpecial Services

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
Aklinski building - 1994	40,045	1,027	11,038
Aklinski concrete work - 1994	3,900	195	1,690
Delaware house - 1996 (less disposition of \$17,550 in 2005-06)	0	262	0
Land - 1994, 1998, 2002, 2005	35,000		
Repp house - 1998	38,500	963	4,452
405 NW 3rd house - 2005	67,629	1012	1,012
Architect fees for Assisted Living - 2005	2,915		
TOTALS	\$ 187,989	\$ 3,459	\$ 18,192

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

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:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

N/A
N/A

9. Option to Buy: YES NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ N/A Description: N/A

(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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

* 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 checked="" 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></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		1,750		1,750
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,750	\$	\$ 1,750
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,750		

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	16
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	16

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,446	\$ 78,060	\$	1,446	\$ 78,060	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		636	35,021		636	35,021	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,852	101,894		1,852	101,894	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				39,776		39,776	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(1), (2)	1104	17,503			5,133	1,104	22,636	12
13	Other (specify): Part A Oxygen	39(2)					7,238		7,238	13
14	TOTAL			\$ 17,503	3,934	\$ 214,975	\$ 52,147	5,038	\$ 284,625	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning: 07/01/2005

Ending:

06/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2006

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 58,403	\$ 58,403	1
2	Cash-Patient Deposits	10,998	10,998	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 18,000)	545,056	545,056	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,004	78,004	6
7	Other Prepaid Expenses	32,187	32,187	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 724,648	\$ 724,648	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	30,051	30,051	12
13	Land	79,545	24,000	13
14	Buildings, at Historical Cost	2,210,898	2,107,366	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	636,333	652,672	16
17	Accumulated Depreciation (book methods)	(1,560,643)	(1,579,823)	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 (spec Security Deposits)	372	372	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,396,556	\$ 1,234,638	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,121,204	\$ 1,959,286	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 157,953	\$ 157,953	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,998	10,998	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	139,658	139,658	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,981	29,981	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	See Sch17A	111,431	111,431	36
37	Employee Benefits Payable	14,005	14,005	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 464,026	\$ 464,026	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	42,906	42,906	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Leases Payable	13,367	13,367	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 56,273	\$ 56,273	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 520,299	\$ 520,299	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,600,905	\$ 1,438,987	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,121,204	\$ 1,959,286	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Heartland Manor Nursing Center

Provider #: 0002923

7/1/2005 to 6/30/2006

Schedule 17A

XV (C). - Line 36 - Other Current Liabilities

Due to Third Party Payor	11,427
Deferred Revenue	100,004
	<u>\$111,431</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,581,057	1
2	Restatements (describe):		2
3			3
4	Prior Period Adjustment	17,506	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,598,563	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,342	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)	\$ 2,342	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)	\$ 1,600,905	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 2,984,074	1
2	Discounts and Allowances for all Levels	(78,988)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,905,086	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	406,528	6
7	Oxygen	69,499	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 476,027	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,008	14
15	Telephone, Television and Radio	2,752	15
16	Rental of Facility Space	13,480	16
17	Sale of Drugs	39,776	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,921	19
20	Radiology and X-Ray	1,711	20
21	Other Medical Services	61,102	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 131,750	23
	D. Non-Operating Revenue		
24	Contributions	2,597	24
25	Interest and Other Investment Income***	11,452	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,049	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	19,760	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 19,760	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,546,672	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	747,378	31
32	Health Care	1,657,119	32
33	General Administration	761,256	33
	B. Capital Expense		
34	Ownership	112,963	34
	C. Ancillary Expense		
35	Special Cost Centers	211,411	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,544,330	40
41	Income before Income Taxes (line 30 minus line 40)**	2,342	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,342	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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Heartland Manor Nursing Center

Provider #: 00002923

7/1/2005 to 6/30/2006

Schedule 19A

XVII (A). - Line 28 - Other Revenue

Vending income	952
Oil income	930
Cleaning income	17,600
Miscellaneous income	278
	<u>\$ 19,760</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

0002923

Report Period Beginning: 07/01/2005

Ending: 06/30/2006

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	1,931	2,080	\$ 49,880	\$ 23.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,779	7,600	213,890	28.14	3
4	Licensed Practical Nurses	15,565	16,848	325,637	19.33	4
5	CNAs & Orderlies	55,778	59,696	579,423	9.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	968	1,040	13,435	12.92	9
10	Activity Assistants	5,947	6,240	47,114	7.55	10
11	Social Service Workers	968	1,040	10,545	10.14	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,080	27,537	13.24	13
14	Head Cook	7,491	7,904	60,604	7.67	14
15	Cook Helpers/Assistants	14,529	15,808	112,115	7.09	15
16	Dishwashers	1,965	2,080	14,415	6.93	16
17	Maintenance Workers	3,057	3,280	45,180	13.77	17
18	Housekeepers	11,832	12,382	98,847	7.98	18
19	Laundry	8,131	8,888	72,326	8.14	19
20	Administrator	1,944	2,080	100,219	48.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,701	8,320	111,928	13.45	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 C: <u>Care Plan Coord.</u>	1,760	2,080	30,138	14.49	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,298	159,446	\$ 1,913,233 *	\$ 12.00	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	117	\$ 5,270	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant	32	1,660	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	1,020	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	1,974	11(3)	44
45	Social Service Consultant	48	1,974	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	281	\$ 17,898		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	257	\$ 12,680	10(3)	50
51	Licensed Practical Nurses	184	6,686	10(3)	51
52	Certified Nurse Assistants/Aides	1,791	37,067	10(3)	52
53	TOTAL (lines 50 - 52)	2,231	\$ 56,433		53

SEE ACCOUNTANTS' COMPILATION REPORT

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		
David J. Sauer	Administrator	0	\$ 100,219	Workers' Compensation Insurance	\$ 44,939	IDPH License Fee	\$ 995		
				Unemployment Compensation Insurance	10,734	Advertising: Employee Recruitment	95		
				FICA Taxes	145,373	Health Care Worker Background Check (Indicate # of checks performed 31)	416		
				Employee Health Insurance	103,971	Patient Background Checks	1,644		
				Employee Meals		Illinois Health Care Association dues	5,465		
				Illinois Municipal Retirement Fund (IMRF)*		CLIA License fee	150		
				Profit Sharing Plan	15,014	Miscellaneous licenses	265		
				Labs/Physicals	3,586	Miscellaneous dues & fees (see Sch 21A)	6,998		
				Other Employee Benefits	41,958	Miscellaneous subscriptions	427		
						Less: Public Relations Expense	(628)		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,219	TOTAL (agree to Schedule V, line 22, col.8)		\$ 365,575	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 15,827
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	
N/A	\$					\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense		
							See attached detail	6,085	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 63,373	TOTAL		\$	TOTAL	\$ 6,085	

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Heartland Manor Nursing Center
Facility ID: 0002923
Year End: 06/30/2006

Schedule 21A

Schedule XIX (F) - Dues, Fees, Subscriptions & Promotions

e-Health Data	1,350
NAEIR	495
Internet Services Provider Fees	960
Rotary Club, Chamber of Commerce & NFIB dues	628
Post Office Box Fees	220
Pitney Bowes	764
401 (k) Service Fee	1,035
Other Dues & Fees	<u>1,546</u>
	<u><u>6,998</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1		\$		\$	\$	\$	\$ N/A	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center# 0002923Report Period Beginning: 07/01/2005Ending: 06/30/2006**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. IL Health Care Association - \$5,465
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 12.5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,974 Line 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 11,008
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Larson, Woodyard & Henson The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit still in progress
- (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 \$2500, 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

SEE ACCOUNTANTS' COMPILATION REPORT