

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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

**I. IDPH Facility ID Number:** 0038356

**Facility Name:** Heritage Manor-Mendota

**Address:** 1201 First Avenue Mendota 61342  
 Number City Zip Code

**County:** LaSalle

**Telephone Number:** ( 815 ) 539-6745 Fax # ( )

**HFS ID Number:** 370909086005

**Date of Initial License for Current Owners:** 1964

**Type of Ownership:**

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

**In the event there are further questions about this report, please contact:**  
**Name:** Craig Ater **Telephone Number:** ( 309 ) 823-7135

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Craig L. Ater</u>	
	(Title) <u>Senior V.P. &amp; CFO</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>( )</u> Fax # <u>( )</u>	
	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630	

Facility Name & ID Number Heritage Manor-Mendota

# 0038356 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	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	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,982</u>	<u>8,428</u>	<u>2,838</u>	<u>26,248</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,982</u>	<u>8,428</u>	<u>2,838</u>	<u>26,248</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.64%

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 1964

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

YES  Date \_\_\_\_\_ NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 2,838

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: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

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

Facility Name & ID Number Heritage Manor-Mendota # 0038356 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	
	<b>A. General Services</b>											
1	Dietary	165,293	15,980		181,273		181,273	5,021	186,294			1
2	Food Purchase		128,072		128,072		128,072	5	128,077			2
3	Housekeeping	71,671	19,059		90,730		90,730		90,730			3
4	Laundry	56,603	13,247		69,850		69,850		69,850			4
5	Heat and Other Utilities			75,082	75,082		75,082	1,348	76,430			5
6	Maintenance	56,943	26,026	35,680	118,649		118,649	12,359	131,008			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>350,510</b>	<b>202,384</b>	<b>110,762</b>	<b>663,656</b>		<b>663,656</b>	<b>18,733</b>	<b>682,389</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			8,430	8,430		8,430	1,850	10,280			9
10	Nursing and Medical Records	1,208,822	82,796	40,031	1,331,649		1,331,649		1,331,649			10
10a	Therapy		191,734	305,725	497,459	(318,577)	178,882	93,692	272,574			10a
11	Activities	63,377	7,236		70,613		70,613	1,319	71,932			11
12	Social Services	28,023	133	1,926	30,082		30,082		30,082			12
13	CNA Training		3,180		3,180		3,180	1,757	4,937			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,300,222</b>	<b>285,079</b>	<b>356,112</b>	<b>1,941,413</b>	<b>(318,577)</b>	<b>1,622,836</b>	<b>98,618</b>	<b>1,721,454</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	66,500			66,500		66,500	68,489	134,989			17
18	Directors Fees							5,662	5,662			18
19	Professional Services			245,729	245,729		245,729	(233,498)	12,231			19
20	Dues, Fees, Subscriptions & Promotions			107,545	107,545	(54,203)	53,343	(30,518)	22,825			20
21	Clerical & General Office Expenses	121,494	7,551	24,055	153,100		153,100	139,001	292,101			21
22	Employee Benefits & Payroll Taxes			451,876	451,876		451,876	32,298	484,174			22
23	Inservice Training & Education			1,363	1,363		1,363	636	1,999			23
24	Travel and Seminar			10,367	10,367		10,367	(8,368)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,058	72,058		72,058	1,900	73,958			26
27	Other (specify):*			6,050	6,050		6,050	(6,050)				27
28	<b>TOTAL General Administration</b>	<b>187,994</b>	<b>7,551</b>	<b>919,043</b>	<b>1,114,588</b>	<b>(54,203)</b>	<b>1,060,386</b>	<b>(30,448)</b>	<b>1,029,938</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,838,726</b>	<b>495,014</b>	<b>1,385,917</b>	<b>3,719,657</b>	<b>(372,780)</b>	<b>3,346,878</b>	<b>86,903</b>	<b>3,433,781</b>			<b>29</b>

\*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-Mendota #0038356 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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	
	<b>D. Ownership</b>											
30	Depreciation			134,723	134,723		134,723	11,180	145,903			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			165,791	165,791		165,791	16,097	181,888			32
33	Real Estate Taxes			29,659	29,659		29,659		29,659			33
34	Rent-Facility & Grounds							6,020	6,020			34
35	Rent-Equipment & Vehicles			488	488		488	1,458	1,946			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			330,661	330,661		330,661	34,755	365,416			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					318,577	318,577		318,577			39
40	Barber and Beauty Shops		492	6,248	6,740		6,740		6,740			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					54,203	54,203		54,203			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		492	6,248	6,740	372,780	379,520		379,520			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,838,726	495,506	1,722,826	4,057,058		4,057,058	121,658	4,178,716			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-Mendota

# 0038356

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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		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	(13)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(17,706)	24		19
20	Contributions	(50)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,670)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	27		24
25	Fund Raising, Advertising and Promotional	(34,900)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (73,339)		\$	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)	194,997		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 194,997		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 121,658		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Mendota

ID# 0038356

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(1,000)	20
18			18
19			24
20		(50)	27
21			21
22		(13,670)	19
23			23
24		(6,000)	27
25		(34,900)	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	<b>Total</b>	(55,620)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Mendota

# 0038356

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	5,021	0	0	0	0	0	0	0	0	5,021	1
2	Food Purchase	0	0	5	0	0	0	0	0	0	0	0	5	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,348	0	0	0	0	0	0	0	0	1,348	5
6	Maintenance	0	0	12,359	0	0	0	0	0	0	0	0	12,359	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	18,733	0	0	0	0	0	0	0	0	18,733	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	1,850	0	0	0	0	0	0	0	0	1,850	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	93,692	0	0	0	0	0	0	0	0	0	93,692	10a
11	Activities	0	0	1,319	0	0	0	0	0	0	0	0	1,319	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,757	0	0	0	0	0	0	0	0	1,757	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	<b>TOTAL Health Care and Programs</b>	0	93,692	4,926	0	0	0	0	0	0	0	0	98,618	16
	<b>C. General Administration</b>													
17	Administrative	0	0	68,489	0	0	0	0	0	0	0	0	68,489	17
18	Directors Fees	0	0	5,662	0	0	0	0	0	0	0	0	5,662	18
19	Professional Services	(13,670)	(232,059)	12,231	0	0	0	0	0	0	0	0	(233,498)	19
20	Fees, Subscriptions & Promotions	(35,900)	0	5,382	0	0	0	0	0	0	0	0	(30,518)	20
21	Clerical & General Office Expenses	0	0	139,001	0	0	0	0	0	0	0	0	139,001	21
22	Employee Benefits & Payroll Taxes	0	0	32,298	0	0	0	0	0	0	0	0	32,298	22
23	Inservice Training & Education	0	0	636	0	0	0	0	0	0	0	0	636	23
24	Travel and Seminar	(17,706)	0	9,338	0	0	0	0	0	0	0	0	(8,368)	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	1,900	0	0	0	0	0	0	0	0	1,900	26
27	Other (specify):*	(6,050)	0	0	0	0	0	0	0	0	0	0	(6,050)	27
28	<b>TOTAL General Administration</b>	(73,326)	(232,059)	274,937	0	0	0	0	0	0	0	0	(30,448)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(73,326)	(138,367)	298,596	0	0	0	0	0	0	0	0	86,903	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Mendota

# 0038356

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	11,180	0	0	0	0	0	0	0	11,180	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13)	0	0	16,110	0	0	0	0	0	0	0	16,097	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	6,020	0	0	0	0	0	0	0	6,020	34
35	Rent-Equipment & Vehicles	0	0	0	1,458	0	0	0	0	0	0	0	1,458	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(13)</b>	<b>0</b>	<b>0</b>	<b>34,768</b>	<b>0</b>	<b>34,755</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(73,339)</b>	<b>(138,367)</b>	<b>298,596</b>	<b>34,768</b>	<b>0</b>	<b>121,658</b>	<b>45</b>						

Facility Name & ID Number Heritage Manor-Mendota

# 0038356

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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						2
3	V							3
4	V	19 Adjustment for Related Organization	232,059	Heritage Enterprises, Inc.			(232,059)	4
5	V							5
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		93,692	93,692	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 232,059			\$ 93,692	\$ * (138,367)	14

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

Facility Name & ID Number Heritage Manor-Mendota# 0038356Report Period Beginning: 01/01/06Ending: 12/31/06

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 5,021	\$ 5,021	15
16	V	2 Food Purchase				5	5	16
17	V	3 Housekeeping				0		17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,348	1,348	19
20	V	6 Maintenance				12,359	12,359	20
21	V	7 Other				0		21
22	V	9 Medical Director				1,850	1,850	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,319	1,319	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				1,757	1,757	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				68,489	68,489	29
30	V	18 Directors Fees				5,662	5,662	30
31	V	19 Professional Services				12,231	12,231	31
32	V	20 Fees, Subscription, Promotions				5,382	5,382	32
33	V	21 Clerical & General Office Expenses				139,001	139,001	33
34	V	22 Employee Benefits & Payroll Taxes				32,298	32,298	34
35	V	23 Inservice Training & Education				636	636	35
36	V	24 Travel and Seminar				9,338	9,338	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				1,900	1,900	38
39	Total		\$			\$ 298,596	\$ * 298,596	39

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

Facility Name & ID Number Heritage Manor-Mendota# 0038356Report Period Beginning: 01/01/06Ending: 12/31/06

## 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	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$	15	
16	V	30 Depreciation				11,180		16	
17	V	31 Amortization of Pre-Op & Org				0		17	
18	V	32 Interest				16,110		18	
19	V	33 Real Estate Taxes				0		19	
20	V	34 Rent-Facility & Grounds				6,020		20	
21	V	35 Rent-Equipment & Vehicles				1,458		21	
22	V	36 Other				0		22	
23	V	38 Medically Nec Transportation				0		23	
24	V	39 Ancillary Service Centers				0		24	
25	V	40 Barber and Beauty Shops				0		25	
26	V	41 Coffee and Gift Shops				0		26	
27	V	42 Other				0		27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$ 34,768	\$ *	34,768	39

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

Facility Name & ID Number Heritage Manor-Mendota # 0038356 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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	Susie Jefferson	Director	Management	15.86		10	100.00	Brd Fees/salar	\$ 15,010	Line 17/18	1
2	Craig Hart	Chairman	Management	31.95		10	100.00	Brd Fees/salary	17,910	Line 17/18	2
3	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Brd Fees/salary	10,247	Line 17/18	3
4	Steve Wannemacher	President	Management	0.42		40	100.00	Brd Fees/salary	13,405	Line 17/18	4
5	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Brd Fees/salary	6,702	Line 17/18	5
6	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Brd Fees/salary	7,555	Line 17/18	6
7	Ben Hart	Vice President	Management	3.20		40	100.00	Brd Fees/salary	3,322	Line 17/18	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 74,151		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-Mendota

# 0038356

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	1	Dietary	Beds 2,624	25	\$ 133,074	\$ 132,833	99	\$ 5,021	1
2	2	Food Purchase	Beds 2,624	25	143	0	99	5	2
3	3	Housekeeping	Beds 2,624	25	0	0	99	0	3
4	4	Laundry	Beds 2,624	25	0	0	99	0	4
5	5	Heat & Other Utilities	Beds 2,624	25	35,724	0	99	1,348	5
6	6	Maintenance	Beds 2,624	25	327,581	62,300	99	12,359	6
7	7	Other	Beds 2,624	25	0	0	99	0	7
8	9	Medical Director	Beds 2,624	25	49,042	0	99	1,850	8
9	10	Nursing & Medical Records	Beds 2,624	25	0	49,042	99	0	9
10	11	Activities	Beds 2,624	25	34,967	0	99	1,319	10
11	12	Social Service	Beds 2,624	25	0	34,801	99	0	11
12	13	Nurse Aide Training	Beds 2,624	25	46,566	41,273	99	1,757	12
13	14	Program Transportation	Beds 2,624	25	0	0	99	0	13
14	15	Other	Beds 2,624	25	0	0	99	0	14
15	17	Administrative	Beds 2,624	25	1,815,310	1,815,310	99	68,489	15
16	18	Directors Fees	Beds 2,624	25	150,067	0	99	5,662	16
17	19	Professional Services	Beds 2,624	25	324,175	0	99	12,231	17
18	20	Fees, Subscription, Promotions	Beds 2,624	25	142,650	0	99	5,382	18
19	21	Clerical & General Office Expense	Beds 2,624	25	3,684,216	3,344,318	99	139,001	19
20	22	Employee Benefits & Payroll Tax	Beds 2,624	25	856,060	0	99	32,298	20
21	23	Inservice Training & Education	Beds 2,624	25	16,846	0	99	636	21
22	24	Travel and Seminar	Beds 2,624	25	247,517	0	99	9,338	22
23	25	Other Admin. Staff Transportatio	Beds 2,624	25	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds 2,624	25	50,353	0	99	1,900	24
25	TOTALS				\$ 7,914,291	\$ 5,479,877		\$ 298,596	25

Facility Name & ID Number Heritage Manor-Mendota

# 0038356

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,624	25	\$	99	\$	1
2	30	Depreciation	Beds	2,624	25	296,327	99	11,180	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		99		3
4	32	Interest	Beds	2,624	25	426,988	99	16,110	4
5	33	Real Estate Taxes	Beds	2,624	25		99		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	159,570	99	6,020	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	38,632	99	1,458	7
8	36	Other	Beds	2,624	25		99		8
9	38	Medically Nec Transportation	Beds	2,624	25		99		9
10	39	Ancillary Service Centers	Beds	2,624	25		99		10
11	40	Barber and Beauty Shops	Beds	2,624	25		99		11
12	41	Coffee and Gift Shops	Beds	2,624	25		99		12
13	42	Other	Beds	2,624	25		99		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					\$ 921,517	\$	\$ 34,768	25

Facility Name & ID Number Heritage Manor-Mendota # 0038356 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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				
		<b>A. Directly Facility Related</b>										
<b>Long-Term</b>												
1	LsSalle National Bank		xx	Mortgage	13440 + Int	4/1/2006	\$	\$ 1,911,045	4/1/2011	variable	\$ 143,418	1
2	LsSalle National Bank		xx	Mortgage							4,438	2
3												3
4												4
5												5
<b>Working Capital</b>												
6	LsSalle National Bank		xx	Working Capital						variable	17,935	6
7	LsSalle National Bank		xx									7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$ 1,911,045			\$ 165,791	9
<b>B. Non-Facility Related*</b>												
10	<b>Interest Income</b>										(13)	10
11	<b>Allocated Corporate</b>										16,110	11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 16,097	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 1,911,045			\$ 181,888	15

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

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Heritage Manor-Mendota COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0038356

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 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. <u>01-34-100-020</u>	<u>Nursing Home</u>	\$ <u>29,324.00</u>	\$ <u>29,324.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>29,324.00</u>	\$ <u>29,324.00</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 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 Heritage Manor-Mendota

# 0038356 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 20,555 B. General Construction Type: Exterior Brick/Wood Frame Wood Number of Stories 1

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

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

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

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

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

none

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>26,150</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>26,150</u>	3

**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	99				\$ 697,500	\$		\$	\$	\$	4
5					408,657						5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	1980 Improvements			1980	8,150						9
10	1981 Improvements			1981	20,492						10
11	1982 Improvements			1982	9,185						11
12	1983 Improvements			1983	5,682						12
13	1984 Improvements			1984	11,488						13
14	1985 Improvements			1985	7,710						14
15	1986 Improvements			1986	2,255						15
16	1987 Improvements			1987	9,037						16
17	1988 Improvements			1988	21,297						17
18	1989 Improvements			1989	4,653						18
19	1990 Improvements			1990	36,595						19
20	1991 Improvements			1991							20
21	1992 Improvements			1992	10,646						21
22	1993 Improvements			1993	62,261						22
23	1994 Improvements			1994	10,869						23
24	1995 Improvements			1995	18,523						24
25	Exterior Door			1996	2,563						25
26	Shower Tile			1996	806						26
27	Kitchen Heat/Cool Unit			1996	14,062						27
28	Resident Room Painting			1996	2,067						28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							11,180	11,180		34
35	Book Depreciation					83,375		83,375		870,029	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 &amp; ID Number Heritage Manor-Mendota

# 0038356

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	Garbage Disposal	1997	\$ 2,030	\$		\$	\$	\$	37
38	Generator	1997	39,380						38
39	Parking Lot Asphalt	1997	2,210						39
40	Shower	1997	701						40
41									41
42	Kitchen Drain	1998	3,245						42
43	Walk in Cooler Repair	1998	2,215						43
44	A/C Unit	1998	1,615						44
45	Landscaping	1998	4,696						45
46									46
47	Door Alarm System	1999	11,750						47
48	Air Conditioning Condensing Unit	1999	1,027						48
49	Water Softener	1999	4,493						49
50									50
51	Air conditioner (3)	2000	2,221						51
52	Sprinklers	2000	1,864						52
53	Resident Room Doors (45)	2000	1,724						53
54	Facility Remodel -- Materials (see attached detail)	2000	410,365						54
55	Facility Remodel -- Labor (see attached detail)	2000	4,030						55
56	Facility Remodel -- Professional Fees (see attached detail)	2000	23,932						56
57	Facility Remodel -- Interior Design (see attached detail)	2000	36,998						57
58	Water Softener	2000	4,713						58
59									59
60	Parking Spaces	2001	1,452						60
61	Water Heater	2001	2,847						61
62									62
63	Water Heater	2002	3,816						63
64	Wood door	2002	677						64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,932,499	\$ 83,375		\$ 94,555	\$ 11,180	\$ 870,029	70

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

Facility Name &amp; ID Number Heritage Manor-Mendota

# 0038356

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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		\$ 1,932,499	\$ 83,375		\$ 94,555	\$ 11,180	\$ 870,029	1
2									2
3	Furnace	2003	2,491						3
4	A/C Unit	2003	3,083						4
5	Condensing Unit	2003	1,353						5
6									6
7	Heat/Cool Unit	2004	2,498						7
8	Disposal	2004	989						8
9	Garage Repairs	2004	4,866						9
10	Compressor	2004	1,805						10
11	Emergency Outlets	2004	1,565						11
12	Furnace	2004	6,280						12
13									13
14	Exterior Door	2005	3,161						14
15	Holding Tank	2005	3,897						15
16	Smoke Detector	2005	1,919						16
17	A/C Unit	2005	4,248						17
18	Parking Lot	2005	68,313						18
19	Dumpster Pad	2005	1,547						19
20	Sidewalks	2005	7,850						20
21									21
22	Floor -- entry way	2006	19,178						22
23	Shower rehab	2006	6,246						23
24	Phone system	2006	1,836						24
25	A/C Unit	2006	2,201						25
26	Compressor	2006	1,642						26
27	Remodel TLC unit -- paint, wallpaper	2006	6,126						27
28	Parking Lot	2006	3,633						28
29	Roof	2006	148,938						29
30	Valance	2006	581						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,238,745	\$ 83,375		\$ 94,555	\$ 11,180	\$ 870,029	34

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

Facility Name & ID Number Heritage Manor-Mendota

# 0038356

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,238,745	\$ 83,375		\$ 94,555	\$ 11,180	\$ 870,029	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)	\$ 2,238,745	\$ 83,375		\$ 94,555	\$ 11,180	\$ 870,029	34

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

Facility Name & ID Number Heritage Manor-Mendota # 0038356 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 717,542	\$ 51,348	\$ 51,348	\$		\$ 605,086	71
72	Current Year Purchases	96,350						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 813,892	\$ 51,348	\$ 51,348	\$		\$ 605,086	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)	\$ 3,078,787	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 134,723	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 145,903	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,180	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,475,115	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	<b>TOTAL</b>				\$ _____			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 1,946 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	<b>TOTAL</b>		\$ _____	\$ _____	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		3,180		3,180
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 3,180	\$	\$ 3,180
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,180		

**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)	
<b>TOTAL TRAINED</b>	

- (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-Mendota# 0038356

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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	\$		\$ 125,248	\$		\$ 125,248	1
2	Licensed Speech and Language Development Therapist		hrs			3,453			3,453	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			143,165	708		143,873	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				284,718		284,718	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					33,859			33,859	13
14	<b>TOTAL</b>			\$		\$ 305,725	\$ 285,426		\$ 591,151	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-Mendota # 0038356 Report Period Beginning: 01/01/06 Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 10,823	\$	1
2	Cash-Patient Deposits	11,922		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	498,410		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,540		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	236,588		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 788,283	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	26,150		13
14	Buildings, at Historical Cost	2,043,778		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	773,968		16
17	Accumulated Depreciation (book methods)	(1,468,895)		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): <u>Loan Fees</u>	21,632		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,396,633	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,184,916	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 93,531	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,922		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	152,280		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,639		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,791		32
33	Accrued Interest Payable	25,980		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 337,143	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,911,045		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Deposits</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,911,045	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,248,188	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (63,272)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,184,916	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,036,595	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,036,595	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(199,867)	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	(1,900,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,099,867)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (63,272)	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Mendota# 0038356Report Period Beginning: 01/01/06Ending: 12/31/06**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,727,368	1
2	Discounts and Allowances for all Levels	(1,233,799)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,493,569	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,021,080	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,021,080	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	787	12
13	Barber and Beauty Care	8,578	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	406	16
17	Sale of Drugs	332,793	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(35)	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 342,529	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 13	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,857,191	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	663,656	31
32	Health Care	1,941,413	32
33	General Administration	1,114,588	33
<b>B. Capital Expense</b>			
34	Ownership	330,661	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	6,740	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37	<u>Non Nursing Home Expenses</u>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,057,058	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(199,867)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (199,867)	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-Mendota

# 0038356

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	1,816	2,177	\$ 49,541	\$ 22.76	1
2	Assistant Director of Nursing	2,021	2,120	46,866	22.11	2
3	Registered Nurses	9,944	10,817	255,538	23.62	3
4	Licensed Practical Nurses	12,775	13,833	283,523	20.50	4
5	CNAs & Orderlies	48,203	51,846	564,536	10.89	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	750	750	8,818	11.76	8
9	Activity Director					9
10	Activity Assistants	5,554	6,123	63,377	10.35	10
11	Social Service Workers	1,841	2,107	28,023	13.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,675	18,896	165,293	8.75	15
16	Dishwashers					16
17	Maintenance Workers	4,737	5,358	56,943	10.63	17
18	Housekeepers	7,006	7,551	71,671	9.49	18
19	Laundry	6,089	6,538	56,603	8.66	19
20	Administrator	1,950	2,080	66,500	31.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,306	7,858	121,494	15.46	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)	126,667	138,054	\$ 1,838,726 *	\$ 13.32	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		8,430		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,970		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		1,926		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,326		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 428		50
51	Licensed Practical Nurses		20,961		51
52	Certified Nurse Assistants/Aides		15,010		52
53	TOTAL (lines 50 - 52)		\$ 36,399		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 \_\_\_\_\_ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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? 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. \$ 14,595
- (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? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_  
**g. Does the facility transport residents to and from day training? \_\_\_\_\_**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Not available at this time
- (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.



Name	Title	Function	Ownership Interest	Compensation Received From Other Homes	Week Devoted to this Business and % of Total Work Week	Description	Compensation in Costs if Reporting	Schedule V Line & Column	Total Pay	Amount Paid by Mgmt	Total # Beds	Facility # Beds	Nursing Home	Nursing Home	This Facility
#REF!	Susie Jeffe	Director	0	382,843	10	0 Salary	15,010	ine 17, col 1	#REF!	417,825	417,825	19,972	397,853	15,010	
#REF!	Craig Hart	Chairman	0	456,799	10	0 Salary	17,910	ine 17, col 1	#REF!	498,540	498,540	23,831	474,709	17,910	
#REF!	Cheryl Lov	Executive	0	261,347	50	1 Salary	10,247	ine 17, col 1	#REF!	285,228	285,228	13,634	271,594	10,247	
#REF!	Steve War	President	0	341,898	50	1 Salary	13,405	ine 17, col 1	#REF!	373,139	373,139	17,836	355,303	13,405	
#REF!	Connie Ho	Sr Vice Pres	0	170,924	40	1 Salary	6,702	ine 17, col 1	#REF!	186,543	186,543	8,917	177,626	6,702	
#REF!	Craig Ater	Sr Vice Pres	0	192,681	50	1 Salary	7,555	ine 17, col 1	#REF!	210,288	210,288	10,052	200,236	7,555	
	Ben Hart	Vice Pres		84,734			3,322			92,476	92,476	4,420	88,056	3,322	
13				1,891,226		TOTAL	74,151		13	2,064,039	2,064,039		1,965,377	74,151	

\* 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 homes(s) as well as the amount paid. This amount must agree to the amounts disclosed.

#REF! 0 ##### total salaries  
70,829 #####

\*\*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.

0 total mgt fees

