

		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:** 0041392

**Facility Name:** Heritage Manor-Minonk

**Address:** 201 Locust Street Minonk 61760  
 Number City Zip Code

**County:** Woodford

**Telephone Number:** ( 309 ) 432-2557 Fax # ( )

**HFS ID Number:** 370909086019

**Date of Initial License for Current Owners:** 1995

**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>	

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

Facility Name & ID Number Heritage Manor-Minonk

# 0041392 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>49</u>	Skilled (SNF)	<u>49</u>	<u>17,885</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>23</u>	Sheltered Care (SC)	<u>23</u>	<u>8,395</u>	5
6		ICF/DD 16 or Less			6
7	<u>72</u>	TOTALS	<u>72</u>	<u>26,280</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>9,051</u>	<u>6,628</u>	<u>1,715</u>	<u>17,394</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	<u>1,354</u>	<u>5,949</u>		<u>7,303</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,405</u>	<u>12,577</u>	<u>1,715</u>	<u>24,697</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.98%

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 1995

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 1,715

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-Minonk # 0041392 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	157,540	14,545		172,085		172,085	3,651	175,736		1
2	Food Purchase		111,480		111,480		111,480	4	111,484		2
3	Housekeeping	69,520	11,989		81,509		81,509		81,509		3
4	Laundry	51,056	7,899		58,955		58,955		58,955		4
5	Heat and Other Utilities			92,253	92,253		92,253	980	93,233		5
6	Maintenance	53,465	23,652	18,005	95,122		95,122	8,989	104,111		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>331,581</b>	<b>169,565</b>	<b>110,258</b>	<b>611,404</b>		<b>611,404</b>	<b>13,624</b>	<b>625,028</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			766	766		766	1,346	2,112		9
10	Nursing and Medical Records	872,105	43,080	3,773	918,958		918,958		918,958		10
10a	Therapy		178,424	182,866	361,290	(254,108)	107,182	71,218	178,400		10a
11	Activities	45,560	4,532		50,092		50,092	959	51,051		11
12	Social Services	25,359		2,321	27,680		27,680		27,680		12
13	CNA Training	2,585	225		2,810		2,810	1,278	4,088		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>945,609</b>	<b>226,261</b>	<b>189,726</b>	<b>1,361,596</b>	<b>(254,108)</b>	<b>1,107,488</b>	<b>74,801</b>	<b>1,182,289</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	70,040			70,040		70,040	49,810	119,850		17
18	Directors Fees							4,118	4,118		18
19	Professional Services			180,055	180,055		180,055	(169,839)	10,216		19
20	Dues, Fees, Subscriptions & Promotions			50,740	50,740	(26,828)	23,913	(8,043)	15,870		20
21	Clerical & General Office Expenses	59,378	5,730	15,296	80,404		80,404	101,091	181,495		21
22	Employee Benefits & Payroll Taxes			275,786	275,786		275,786	23,489	299,275		22
23	Inservice Training & Education			1,537	1,537		1,537	462	1,999		23
24	Travel and Seminar			13,077	13,077		13,077	(11,078)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			52,815	52,815		52,815	1,382	54,197		26
27	Other (specify):*			26,785	26,785		26,785	(26,198)	587		27
28	<b>TOTAL General Administration</b>	<b>129,418</b>	<b>5,730</b>	<b>616,091</b>	<b>751,239</b>	<b>(26,828)</b>	<b>724,412</b>	<b>(34,806)</b>	<b>689,606</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,406,608</b>	<b>401,556</b>	<b>916,075</b>	<b>2,724,239</b>	<b>(280,936)</b>	<b>2,443,304</b>	<b>53,619</b>	<b>2,496,923</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-Minonk #0041392 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			63,677	63,677		63,677	8,131	71,808			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			95,392	95,392		95,392	11,552	106,944			32
33	Real Estate Taxes			34,473	34,473		34,473		34,473			33
34	Rent-Facility & Grounds							4,378	4,378			34
35	Rent-Equipment & Vehicles			839	839		839	1,060	1,899			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			194,381	194,381		194,381	25,121	219,502			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					254,108	254,108		254,108			39
40	Barber and Beauty Shops		20		20		20		20			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					26,828	26,828		26,828			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		20		20	280,936	280,956		280,956			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,406,608	401,576	1,110,456	2,918,640		2,918,640	78,740	2,997,380			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-Minonk

# 0041392

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	(164)	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	(346)	20		17
18	Fines and Penalties				18
19	Entertainment	(17,870)	24		19
20	Contributions	(198)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,480)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,000)	27		24
25	Fund Raising, Advertising and Promotional	(11,611)	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>	\$ (60,669)		\$	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)	139,409		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 139,409		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 78,740		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-Minonk

ID# 0041392

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		(346)	20
18			18
19			24
20		(198)	27
21			21
22		(4,480)	19
23			23
24		(26,000)	27
25		(11,611)	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>	(42,635)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Minonk# 0041392

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	3,651	0	0	0	0	0	0	0	0	3,651	1
2	Food Purchase	0	0	4	0	0	0	0	0	0	0	0	4	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	980	0	0	0	0	0	0	0	0	980	5
6	Maintenance	0	0	8,989	0	0	0	0	0	0	0	0	8,989	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	13,624	0	0	0	0	0	0	0	0	13,624	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	1,346	0	0	0	0	0	0	0	0	1,346	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	71,218	0	0	0	0	0	0	0	0	0	71,218	10a
11	Activities	0	0	959	0	0	0	0	0	0	0	0	959	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,278	0	0	0	0	0	0	0	0	1,278	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	71,218	3,583	0	0	0	0	0	0	0	0	74,801	16
	<b>C. General Administration</b>													
17	Administrative	0	0	49,810	0	0	0	0	0	0	0	0	49,810	17
18	Directors Fees	0	0	4,118	0	0	0	0	0	0	0	0	4,118	18
19	Professional Services	(4,480)	(174,254)	8,895	0	0	0	0	0	0	0	0	(169,839)	19
20	Fees, Subscriptions & Promotions	(11,957)	0	3,914	0	0	0	0	0	0	0	0	(8,043)	20
21	Clerical & General Office Expenses	0	0	101,091	0	0	0	0	0	0	0	0	101,091	21
22	Employee Benefits & Payroll Taxes	0	0	23,489	0	0	0	0	0	0	0	0	23,489	22
23	Inservice Training & Education	0	0	462	0	0	0	0	0	0	0	0	462	23
24	Travel and Seminar	(17,870)	0	6,792	0	0	0	0	0	0	0	0	(11,078)	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	1,382	0	0	0	0	0	0	0	0	1,382	26
27	Other (specify):*	(26,198)	0	0	0	0	0	0	0	0	0	0	(26,198)	27
28	<b>TOTAL General Administration</b>	(60,505)	(174,254)	199,953	0	0	0	0	0	0	0	0	(34,806)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(60,505)	(103,036)	217,160	0	0	0	0	0	0	0	0	53,619	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Minonk

# 0041392

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	8,131	0	0	0	0	0	0	0	8,131	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(164)	0	0	11,716	0	0	0	0	0	0	0	11,552	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	4,378	0	0	0	0	0	0	0	4,378	34
35	Rent-Equipment & Vehicles	0	0	0	1,060	0	0	0	0	0	0	0	1,060	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(164)</b>	<b>0</b>	<b>0</b>	<b>25,285</b>	<b>0</b>	<b>25,121</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>(60,669)</b>	<b>(103,036)</b>	<b>217,160</b>	<b>25,285</b>	<b>0</b>	<b>78,740</b>	<b>45</b>						

**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	174,254	Heritage Enterprises, Inc.			(174,254)	4
5	V							5
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		71,218	71,218	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 174,254			\$ 71,218	\$ * (103,036)	14

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

Facility Name & ID Number Heritage Manor-Minonk# 0041392Report 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%	\$ 3,651	\$ 3,651	15
16	V	2 Food Purchase				4	4	16
17	V	3 Housekeeping				0		17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				980	980	19
20	V	6 Maintenance				8,989	8,989	20
21	V	7 Other				0		21
22	V	9 Medical Director				1,346	1,346	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				959	959	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				1,278	1,278	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				49,810	49,810	29
30	V	18 Directors Fees				4,118	4,118	30
31	V	19 Professional Services				8,895	8,895	31
32	V	20 Fees, Subscription, Promotions				3,914	3,914	32
33	V	21 Clerical & General Office Expenses				101,091	101,091	33
34	V	22 Employee Benefits & Payroll Taxes				23,489	23,489	34
35	V	23 Inservice Training & Education				462	462	35
36	V	24 Travel and Seminar				6,792	6,792	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				1,382	1,382	38
39	Total		\$			\$ 217,160	\$ * 217,160	39

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

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/06 Ending: 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				8,131	8,131	16	
17	V	31 Amortization of Pre-Op & Org				0		17	
18	V	32 Interest				11,716	11,716	18	
19	V	33 Real Estate Taxes				0		19	
20	V	34 Rent-Facility & Grounds				4,378	4,378	20	
21	V	35 Rent-Equipment & Vehicles				1,060	1,060	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		\$			\$ 25,285	\$ *	25,285	39

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

Facility Name & ID Number Heritage Manor-Minonk # 0041392 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	\$ 10,917	Line 17/18	1
2	Craig Hart	Chairman	Management	31.95		10	100.00	Brd Fees/salary	13,026	Line 17/18	2
3	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Brd Fees/salary	7,452	Line 17/18	3
4	Steve Wannemacher	President	Management	0.42		40	100.00	Brd Fees/salary	9,749	Line 17/18	4
5	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Brd Fees/salary	4,874	Line 17/18	5
6	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Brd Fees/salary	5,494	Line 17/18	6
7	Ben Hart	Vice President	Management	3.20		40	100.00	Brd Fees/salary	2,416	Line 17/18	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 53,928		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-Minonk

# 0041392

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	72	\$ 3,651	1
2	2	Food Purchase	Beds 2,624	25	143	0	72	4	2
3	3	Housekeeping	Beds 2,624	25	0	0	72	0	3
4	4	Laundry	Beds 2,624	25	0	0	72	0	4
5	5	Heat & Other Utilities	Beds 2,624	25	35,724	0	72	980	5
6	6	Maintenance	Beds 2,624	25	327,581	62,300	72	8,989	6
7	7	Other	Beds 2,624	25	0	0	72	0	7
8	9	Medical Director	Beds 2,624	25	49,042	0	72	1,346	8
9	10	Nursing & Medical Records	Beds 2,624	25	0	49,042	72	0	9
10	11	Activities	Beds 2,624	25	34,967	0	72	959	10
11	12	Social Service	Beds 2,624	25	0	34,801	72	0	11
12	13	Nurse Aide Training	Beds 2,624	25	46,566	41,273	72	1,278	12
13	14	Program Transportation	Beds 2,624	25	0	0	72	0	13
14	15	Other	Beds 2,624	25	0	0	72	0	14
15	17	Administrative	Beds 2,624	25	1,815,310	1,815,310	72	49,810	15
16	18	Directors Fees	Beds 2,624	25	150,067	0	72	4,118	16
17	19	Professional Services	Beds 2,624	25	324,175	0	72	8,895	17
18	20	Fees, Subscription, Promotions	Beds 2,624	25	142,650	0	72	3,914	18
19	21	Clerical & General Office Expense	Beds 2,624	25	3,684,216	3,344,318	72	101,091	19
20	22	Employee Benefits & Payroll Tax	Beds 2,624	25	856,060	0	72	23,489	20
21	23	Inservice Training & Education	Beds 2,624	25	16,846	0	72	462	21
22	24	Travel and Seminar	Beds 2,624	25	247,517	0	72	6,792	22
23	25	Other Admin. Staff Transportatio	Beds 2,624	25	0	0	72	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds 2,624	25	50,353	0	72	1,382	24
25	TOTALS				\$ 7,914,291	\$ 5,479,877		\$ 217,160	25

Facility Name & ID Number Heritage Manor-Minonk

# 0041392

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,624	25	\$	72	\$	1
2	30	Depreciation	Beds	2,624	25	296,327	72	8,131	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		72		3
4	32	Interest	Beds	2,624	25	426,988	72	11,716	4
5	33	Real Estate Taxes	Beds	2,624	25		72		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	159,570	72	4,378	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	38,632	72	1,060	7
8	36	Other	Beds	2,624	25		72		8
9	38	Medically Nec Transportation	Beds	2,624	25		72		9
10	39	Ancillary Service Centers	Beds	2,624	25		72		10
11	40	Barber and Beauty Shops	Beds	2,624	25		72		11
12	41	Coffee and Gift Shops	Beds	2,624	25		72		12
13	42	Other	Beds	2,624	25		72		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	\$	\$ 25,285	25

Facility Name & ID Number Heritage Manor-Minonk # 0041392 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	\$	\$ 1,078,201	4/1/2011	variable	\$ 82,691	1
2	LsSalle National Bank		xx	Mortgage							3,815	2
3												3
4												4
5												5
<b>Working Capital</b>												
6	LsSalle National Bank		xx	Working Capital						variable	8,886	6
7	LsSalle National Bank		xx									7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$ 1,078,201			\$ 95,392	9
<b>B. Non-Facility Related*</b>												
10	Interest Income										(164)	10
11	Allocated Corporate										11,716	11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 11,552	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 1,078,201			\$ 106,944	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-Minonk COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0041392

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>06-07-407-010</u>	<u>Nursing Home</u>	\$ <u>10,508.00</u>	\$ <u>10,508.00</u>
2. <u>06-07-407-011</u>	<u></u>	\$ <u>22,372.00</u>	\$ <u>22,372.00</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
<b>TOTALS</b>		\$ <u>32,880.00</u>	\$ <u>32,880.00</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-Minok

# 0041392 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 7,560 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>25,000</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>25,000</u>	3

Facility Name &amp; ID Number Heritage Manor-Minonk

# 0041392

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		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	72				\$ 1,039,908	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Smoke Detectors (45)		1998	3,267						9
10		Compressor		1998	1,047						10
11		Generator		1998	12,140						11
12		A/C Repair		1998	1,518						12
13		Plumbing Repair		1998	4,956						13
14											14
15		Water Heater		1996	2,603						15
16		Resident Room Renovating		1996	8,483						16
17		Exterior Painting & Renovation		1996	4,806						17
18		Nurse Call System		1996	3,803						18
19		Garbage Disposal		1996	867						19
20		Boiler Repair		1996	4,436						20
21		Receptionist Work Area Renovation		1996	1,260						21
22		Hot Water Heater		1996	505						22
23		Exterior Signage		1996	1,680						23
24		Interior Rehab		1996	146,288						24
25		Interior Rehab		1996	22,963						25
26		Code Alert System		1996	1,319						26
27											27
28		Interior Rehab		1997	33,578						28
29		Interior Rehab		1997	168						29
30		Building Purchase Offset		1997	(141,199)						30
31											31
32											32
33											33
34		C/O Allocation						8,131	8,131		34
35		Book Depreciation				52,081		52,081		413,835	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Minonk# 0041392

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	Door Alarm System	1999	\$ 10,116	\$		\$	\$	\$	37
38	Plumbing / Water Heater	1999	3,170						38
39	Sewage Ejector	1999	3,042						39
40									40
41	Water Heater	2000	3,293						41
42	Remove and replace patio	2000	5,890						42
43									43
44	Garbage Disposal	2001	922						44
45	Painting--Hallways/Resident rooms	2001	2,444						45
46									46
47	Water Faucet	2002	1,656						47
48	Boiler	2002	17,945						48
49	Shower Faucet	2002	2,398						49
50									50
51	Roof	2003	30,757						51
52	Faucets	2003	1,915						52
53	Compressor	2003	1,126						53
54	Disposal	2003	970						54
55									55
56	Water Heater	2004	3,889						56
57	Hot Water Storage Tank	2004	1,744						57
58	Ansul System	2004	1,455						58
59	Door Alarm System	2004	10,914						59
60	Heat Exchanger	2004	1,518						60
61									61
62	Sewage Ejector	2005	3,310						62
63	Circulator Motor	2005	892						63
64	Dry Valve	2005	2,410						64
65	Integrety Bather	2005	827						65
66	Exterior Doors	2005	6,106						66
67	Sprinkler Repair	2005	2,957						67
68	Glass Door	2005	361						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,276,423	\$ 52,081		\$ 60,212	\$ 8,131	\$ 413,835	70

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

Facility Name & ID Number Heritage Manor-Minonk

# 0041392

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		\$ 1,276,423	\$ 52,081		\$ 60,212	\$ 8,131	\$ 413,835	1
2									2
3	Climate Control	2006	1,299						3
4	Shower Faucet	2006	444						4
5	Sprinkler main line	2006	6,672						5
6	Compressor	2006	1,580						6
7	Corridor Rehab	2006	5,855						7
8	Rooftop A/C	2006	8,235						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)		\$ 1,300,508	\$ 52,081		\$ 60,212	\$ 8,131	\$ 413,835	34

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

Facility Name & ID Number Heritage Manor-Minonk

# 0041392

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		\$ 1,300,508	\$ 52,081		\$ 60,212	\$ 8,131	\$ 413,835	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)	\$ 1,300,508	\$ 52,081		\$ 60,212	\$ 8,131	\$ 413,835	34

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

Facility Name & ID Number Heritage Manor-Minonk # 0041392 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	\$ 202,940	\$ 11,596	\$ 11,596	\$		\$ 162,713	71
72	Current Year Purchases	20,869						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 223,809	\$ 11,596	\$ 11,596	\$		\$ 162,713	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,549,317	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 63,677	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 71,808	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,131	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 576,548	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: \$ 1,899 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		225		225
3	Classroom Wages (a)		2,585		2,585
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 2,810	\$	\$ 2,810
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,810		

**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-Minonk# 0041392

Report Period Beginning:

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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	\$		\$ 83,688	\$		\$ 83,688	1
2	Licensed Speech and Language Development Therapist		hrs			8,616			8,616	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			84,804	1,292		86,096	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				248,350		248,350	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					5,758			5,758	13
14	TOTAL			\$		\$ 182,866	\$ 249,642		\$ 432,508	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-Minonk# 0041392Report Period Beginning: 01/01/06

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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	\$ 71,758	\$	1
2	Cash-Patient Deposits	3,184		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	279,881		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,009		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(64,897)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 290,935	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	1,300,509		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	223,810		16
17	Accumulated Depreciation (book methods)	(576,548)		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>	19,417		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 992,188	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,283,123	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 58,226	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,184		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	148,464		30
31	Accrued Taxes Payable (excluding real estate taxes)	758		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,523		32
33	Accrued Interest Payable	14,930		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>	\$ 260,085	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,078,201		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>	\$ 1,078,201	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,338,286	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (55,163)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,283,123	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,186,979	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,186,979	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(17,142)	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	(2,225,000)	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)	\$ (2,242,142)	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)	\$ (55,163)	24 *

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

Facility Name & ID Number Heritage Manor-Minonk# 0041392Report 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	\$ 2,733,232	1
2	Discounts and Allowances for all Levels	(720,644)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,012,588	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	562,242	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 562,242	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	(13)	12
13	Barber and Beauty Care	2,282	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	306,150	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	18,085	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 326,504	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	164	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 164	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>	\$ 2,901,498	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	611,404	31
32	Health Care	1,361,596	32
33	General Administration	751,239	33
<b>B. Capital Expense</b>			
34	Ownership	194,381	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	20	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37	<b>Non Nursing Home Expenses</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,918,640	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(17,142)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (17,142)	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-Minonk

# 0041392

Report Period Beginning:

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Ending:

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**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,856	1,888	\$ 47,454	\$ 25.13	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,143	8,597	192,989	22.45	3
4	Licensed Practical Nurses	6,379	7,615	140,566	18.46	4
5	CNAs & Orderlies	41,800	44,657	480,115	10.75	5
6	CNA Trainees	250	250	2,585	10.34	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	952	1,160	10,981	9.47	8
9	Activity Director					9
10	Activity Assistants	3,884	4,086	45,560	11.15	10
11	Social Service Workers	1,320	1,534	25,359	16.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,198	13,058	157,540	12.06	15
16	Dishwashers					16
17	Maintenance Workers	4,432	4,904	53,465	10.90	17
18	Housekeepers	7,361	7,918	69,520	8.78	18
19	Laundry	6,110	6,373	51,056	8.01	19
20	Administrator	1,950	2,080	70,040	33.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,788	4,261	59,378	13.94	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)	104,423	108,381	\$ 1,406,608 *	\$ 12.98	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		766		36
37	Medical Records Consultant		1,560		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,160		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,241		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 6,727		49

**C. CONTRACT NURSES**

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





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ 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. \$ 26,828  
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. \$ 4,871
- (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.

Line	Account	Debit	Credit	Balance
1000	1000			
1001	1001			
1002	1002			
1003	1003			
1004	1004			
1005	1005			
1006	1006			
1007	1007			
1008	1008			
1009	1009			
1010	1010			
1011	1011			
1012	1012			
1013	1013			
1014	1014			
1015	1015			
1016	1016			
1017	1017			
1018	1018			
1019	1019			
1020	1020			
1021	1021			
1022	1022			
1023	1023			
1024	1024			
1025	1025			
1026	1026			
1027	1027			
1028	1028			
1029	1029			
1030	1030			
1031	1031			
1032	1032			
1033	1033			
1034	1034			
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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	386,936	10	0 Salary	10,917	ine 17, col 1	#REF!	417,825	417,825	19,972	397,853	10,917	
#REF!	Craig Hart	Chairman	0	461,683	10	0 Salary	13,026	ine 17, col 1	#REF!	498,540	498,540	23,831	474,709	13,026	
#REF!	Cheryl Lov	Executive	0	264,142	50	1 Salary	7,452	ine 17, col 1	#REF!	285,228	285,228	13,634	271,594	7,452	
#REF!	Steve War	President	0	345,554	50	1 Salary	9,749	ine 17, col 1	#REF!	373,139	373,139	17,836	355,303	9,749	
#REF!	Connie Ho	Sr Vice Pres	0	172,752	40	1 Salary	4,874	ine 17, col 1	#REF!	186,543	186,543	8,917	177,626	4,874	
#REF!	Craig Ater	Sr Vice Pres	0	194,742	50	1 Salary	5,494	ine 17, col 1	#REF!	210,288	210,288	10,052	200,236	5,494	
	Ben Hart	Vice Pres		85,640			2,416			92,476	92,476	4,420	88,056	2,416	
13				1,911,449		TOTAL	53,928		13	2,064,039	2,064,039		1,965,377	53,928	

\* 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  
51,512 #####

\*\*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

