

		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: 0041533

Facility Name: Heritage Manor-Pana

Address: 1000 East Sixth Street Road Pana 62557
 Number City Zip Code

County: Montgomery

Telephone Number: (217) 324-2153 Fax # ()

HFS ID Number: 370909086020

Date of Initial License for Current Owners: 1996

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
IRS Exemption Code _____	<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.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Craig L. Ater</u>	
	(Title) <u>Senior V.P. & CFO</u>	
Paid Preparer	(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-Pana

0041533 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	151	Skilled (SNF)	151	55,115	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	151	TOTALS	151	55,115	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	28,137	10,125	5,689	43,951	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,137	10,125	5,689	43,951	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.74%

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 1996

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 5,689

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-Pana # 0041533 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	
	A. General Services											
1	Dietary	222,557	18,577		241,134		241,134	7,658	248,792			1
2	Food Purchase		236,768		236,768		236,768	8	236,776			2
3	Housekeeping	88,182	19,164		107,346		107,346		107,346			3
4	Laundry	78,945	22,925		101,870		101,870		101,870			4
5	Heat and Other Utilities			117,238	117,238		117,238	2,056	119,294			5
6	Maintenance	85,535	49,201	27,457	162,193		162,193	18,851	181,044			6
7	Other (specify):*											7
8	TOTAL General Services	475,219	346,635	144,695	966,549		966,549	28,573	995,122			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800	2,822	19,622			9
10	Nursing and Medical Records	1,781,500	74,567	7,212	1,863,279		1,863,279		1,863,279			10
10a	Therapy		375,646	564,854	940,500	(636,231)	304,269	229,122	533,391			10a
11	Activities	54,843	1,180		56,023		56,023	2,012	58,035			11
12	Social Services	69,723		3,135	72,858		72,858		72,858			12
13	CNA Training		231		231		231	2,680	2,911			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,906,066	451,624	592,001	2,949,691	(636,231)	2,313,460	236,636	2,550,096			16
	C. General Administration											
17	Administrative	85,168			85,168		85,168	104,463	189,631			17
18	Directors Fees							8,636	8,636			18
19	Professional Services			379,996	379,996		379,996	(361,341)	18,655			19
20	Dues, Fees, Subscriptions & Promotions			116,182	116,182	(82,673)	33,510	(6,600)	26,910			20
21	Clerical & General Office Expenses	123,783	16,847	18,034	158,664		158,664	212,011	370,675			21
22	Employee Benefits & Payroll Taxes			561,232	561,232		561,232	49,263	610,495			22
23	Inservice Training & Education			1,030	1,030		1,030	969	1,999			23
24	Travel and Seminar			15,842	15,842		15,842	(13,843)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			109,359	109,359		109,359	2,898	112,257			26
27	Other (specify):*			501	501		501	(75)	426			27
28	TOTAL General Administration	208,951	16,847	1,202,176	1,427,974	(82,673)	1,345,302	(3,619)	1,341,683			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,590,236	815,106	1,938,872	5,344,214	(718,904)	4,625,311	261,590	4,886,901			29

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

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

Facility Name & ID Number Heritage Manor-Pana #0041533 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			133,030	133,030		133,030	17,052	150,082			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			246,154	246,154		246,154	24,515	270,669			32
33	Real Estate Taxes			67,142	67,142		67,142		67,142			33
34	Rent-Facility & Grounds							9,183	9,183			34
35	Rent-Equipment & Vehicles			22,549	22,549		22,549	2,223	24,772			35
36	Other (specify):*											36
37	TOTAL Ownership			468,875	468,875		468,875	52,973	521,848			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					636,231	636,231		636,231			39
40	Barber and Beauty Shops		1,146	24,288	25,434		25,434		25,434			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					82,673	82,673		82,673			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,146	24,288	25,434	718,904	744,338		744,338			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,590,236	816,252	2,432,035	5,838,523		5,838,523	314,563	6,153,086			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-Pana

0041533

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	(56)	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	(835)	20		17
18	Fines and Penalties				18
19	Entertainment	(28,087)	24		19
20	Contributions	(75)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,913)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(13,974)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (46,940)		\$	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)	361,503		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 361,503		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 314,563		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Pana

ID# 0041533

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		(835)	20
18			18
19			24
20		(75)	27
21			21
22		(3,913)	19
23			23
24		0	27
25		(13,974)	20
26			26
27			27
28			28
29		0	33
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(18,797)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Pana# 0041533

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)	
	A. General Services													
1	Dietary	0	0	7,658	0	0	0	0	0	0	0	0	7,658	1
2	Food Purchase	0	0	8	0	0	0	0	0	0	0	0	8	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	2,056	0	0	0	0	0	0	0	0	2,056	5
6	Maintenance	0	0	18,851	0	0	0	0	0	0	0	0	18,851	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	28,573	0	0	0	0	0	0	0	0	28,573	8
	B. Health Care and Programs													
9	Medical Director	0	0	2,822	0	0	0	0	0	0	0	0	2,822	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	229,122	0	0	0	0	0	0	0	0	0	229,122	10a
11	Activities	0	0	2,012	0	0	0	0	0	0	0	0	2,012	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	2,680	0	0	0	0	0	0	0	0	2,680	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	229,122	7,514	0	0	0	0	0	0	0	0	236,636	16
	C. General Administration													
17	Administrative	0	0	104,463	0	0	0	0	0	0	0	0	104,463	17
18	Directors Fees	0	0	8,636	0	0	0	0	0	0	0	0	8,636	18
19	Professional Services	(3,913)	(376,083)	18,655	0	0	0	0	0	0	0	0	(361,341)	19
20	Fees, Subscriptions & Promotions	(14,809)	0	8,209	0	0	0	0	0	0	0	0	(6,600)	20
21	Clerical & General Office Expenses	0	0	212,011	0	0	0	0	0	0	0	0	212,011	21
22	Employee Benefits & Payroll Taxes	0	0	49,263	0	0	0	0	0	0	0	0	49,263	22
23	Inservice Training & Education	0	0	969	0	0	0	0	0	0	0	0	969	23
24	Travel and Seminar	(28,087)	0	14,244	0	0	0	0	0	0	0	0	(13,843)	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	2,898	0	0	0	0	0	0	0	0	2,898	26
27	Other (specify):*	(75)	0	0	0	0	0	0	0	0	0	0	(75)	27
28	TOTAL General Administration	(46,884)	(376,083)	419,348	0	0	0	0	0	0	0	0	(3,619)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,884)	(146,961)	455,435	0	0	0	0	0	0	0	0	261,590	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Pana

0041533

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	17,052	0	0	0	0	0	0	0	17,052	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(56)	0	0	24,571	0	0	0	0	0	0	0	24,515	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	9,183	0	0	0	0	0	0	0	9,183	34
35	Rent-Equipment & Vehicles	0	0	0	2,223	0	0	0	0	0	0	0	2,223	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(56)	0	0	53,029	0	52,973	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(46,940)	(146,961)	455,435	53,029	0	314,563	45						

Facility Name & ID Number Heritage Manor-Pana

0041533

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	376,083	Heritage Enterprises, Inc.			(376,083)	4
5	V							5
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		229,122	229,122	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 376,083			\$ 229,122	\$ * (146,961)	14

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

Facility Name & ID Number Heritage Manor-Pana # 0041533 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 7,658	\$ 7,658	15
16	V	2 Food Purchase				8	8	16
17	V	3 Housekeeping				0		17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				2,056	2,056	19
20	V	6 Maintenance				18,851	18,851	20
21	V	7 Other				0		21
22	V	9 Medical Director				2,822	2,822	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				2,012	2,012	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				2,680	2,680	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				104,463	104,463	29
30	V	18 Directors Fees				8,636	8,636	30
31	V	19 Professional Services				18,655	18,655	31
32	V	20 Fees, Subscription, Promotions				8,209	8,209	32
33	V	21 Clerical & General Office Expenses				212,011	212,011	33
34	V	22 Employee Benefits & Payroll Taxes				49,263	49,263	34
35	V	23 Inservice Training & Education				969	969	35
36	V	24 Travel and Seminar				14,244	14,244	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				2,898	2,898	38
39	Total		\$			\$ 455,435	\$ * 455,435	39

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

Facility Name & ID Number Heritage Manor-Pana # 0041533 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				17,052		17,052 16
17	V	31 Amortization of Pre-Op & Org				0		17
18	V	32 Interest				24,571		24,571 18
19	V	33 Real Estate Taxes				0		19
20	V	34 Rent-Facility & Grounds				9,183		9,183 20
21	V	35 Rent-Equipment & Vehicles				2,223		2,223 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		\$			\$ 53,029	\$ *	53,029 39

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

Facility Name & ID Number Heritage Manor-Pana # 0041533 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	\$ 22,895	Line 17/18	1
2	Craig Hart	Chairman	Management	31.95		10	100.00	Brd Fees/salary	27,317	Line 17/18	2
3	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Brd Fees/salary	15,629	Line 17/18	3
4	Steve Wannemacher	President	Management	0.42		40	100.00	Brd Fees/salary	20,446	Line 17/18	4
5	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Brd Fees/salary	10,222	Line 17/18	5
6	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Brd Fees/salary	11,523	Line 17/18	6
7	Ben Hart	Vice President	Management	3.20		40	100.00	Brd Fees/salary	5,067	Line 17/18	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 113,099		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-Pana

0041533

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	151	\$ 7,658	1
2	2	Food Purchase	Beds 2,624	25	143	0	151	8	2
3	3	Housekeeping	Beds 2,624	25	0	0	151	0	3
4	4	Laundry	Beds 2,624	25	0	0	151	0	4
5	5	Heat & Other Utilities	Beds 2,624	25	35,724	0	151	2,056	5
6	6	Maintenance	Beds 2,624	25	327,581	62,300	151	18,851	6
7	7	Other	Beds 2,624	25	0	0	151	0	7
8	9	Medical Director	Beds 2,624	25	49,042	0	151	2,822	8
9	10	Nursing & Medical Records	Beds 2,624	25	0	49,042	151	0	9
10	11	Activities	Beds 2,624	25	34,967	0	151	2,012	10
11	12	Social Service	Beds 2,624	25	0	34,801	151	0	11
12	13	Nurse Aide Training	Beds 2,624	25	46,566	41,273	151	2,680	12
13	14	Program Transportation	Beds 2,624	25	0	0	151	0	13
14	15	Other	Beds 2,624	25	0	0	151	0	14
15	17	Administrative	Beds 2,624	25	1,815,310	1,815,310	151	104,463	15
16	18	Directors Fees	Beds 2,624	25	150,067	0	151	8,636	16
17	19	Professional Services	Beds 2,624	25	324,175	0	151	18,655	17
18	20	Fees, Subscription, Promotions	Beds 2,624	25	142,650	0	151	8,209	18
19	21	Clerical & General Office Expense	Beds 2,624	25	3,684,216	3,344,318	151	212,011	19
20	22	Employee Benefits & Payroll Tax	Beds 2,624	25	856,060	0	151	49,263	20
21	23	Inservice Training & Education	Beds 2,624	25	16,846	0	151	969	21
22	24	Travel and Seminar	Beds 2,624	25	247,517	0	151	14,244	22
23	25	Other Admin. Staff Transportatio	Beds 2,624	25	0	0	151	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds 2,624	25	50,353	0	151	2,898	24
25	TOTALS				\$ 7,914,291	\$ 5,479,877		\$ 455,435	25

Facility Name & ID Number Heritage Manor-Pana

0041533

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	\$	151	\$	1
2	30	Depreciation	Beds	2,624	25	296,327	151	17,052	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		151		3
4	32	Interest	Beds	2,624	25	426,988	151	24,571	4
5	33	Real Estate Taxes	Beds	2,624	25		151		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	159,570	151	9,183	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	38,632	151	2,223	7
8	36	Other	Beds	2,624	25		151		8
9	38	Medically Nec Transportation	Beds	2,624	25		151		9
10	39	Ancillary Service Centers	Beds	2,624	25		151		10
11	40	Barber and Beauty Shops	Beds	2,624	25		151		11
12	41	Coffee and Gift Shops	Beds	2,624	25		151		12
13	42	Other	Beds	2,624	25		151		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	\$	\$ 53,029	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LsSalle National Bank		xx	Mortgage	13440 + Int	4/1/2006	\$	\$ 2,874,390	4/1/2011	variable	\$ 208,763	1								
2	LsSalle National Bank		xx	Mortgage							10,042	2								
3												3								
4												4								
5												5								
Working Capital																				
6	LsSalle National Bank		xx	Working Capital						variable	27,349	6								
7	LsSalle National Bank		xx									7								
8												8								
9	TOTAL Facility Related						\$	\$ 2,874,390			\$ 246,154	9								
B. Non-Facility Related*																				
10	Interest Income										(56)	10								
11	Allocated Corporate										24,571	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 24,515	14								
15	TOTALS (line 9+line14)						\$	\$ 2,874,390			\$ 270,669	15								

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.		\$	64,610	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	64,269	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(341)	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	67,483	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	67,142	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	<u>54,205</u>	<u>8</u>	
	2002	<u>49,636</u>	<u>9</u>	
	2003	<u>55,832</u>	<u>10</u>	
	2004	<u>57,719</u>	<u>11</u>	
	2005	<u>67,680</u>	<u>12</u>	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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-Pana COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0041533

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>11-25-22-223-013</u>	<u>Nursing Home</u>	\$ <u>678.00</u>	\$ <u>678.00</u>
2. <u>11-25-22-223-014</u>	<u></u>	\$ <u>63,591.00</u>	\$ <u>63,591.00</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>
TOTALS		\$ <u>64,269.00</u>	\$ <u>64,269.00</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-Pana

0041533 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,284 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>51,055</u>	1
2					2
3	TOTALS			\$ <u>51,055</u>	3

Facility Name & ID Number Heritage Manor-Pana

0041533

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	60				\$ 3,943,054	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Smoke Detectors										10
11			1997		1,113						11
12	Seal BlackTop/Parking Lot										12
13	Heritage Manor Sign		1996		2,680						13
14	Laundry Room Central A/C		1996		2,192						14
15			1996		3,019						15
16	Generator Repair										16
17	Roof		1998		1,559						17
18			1998		26,420						18
19	roof										19
20			1999		113,936						20
21	Heat / Cool Unit										21
22	Roof Repair Walkway		2000		1,170						22
23			2000		1,715						23
24											24
25	Tile Floor										25
26	Heat/Cool Unit		2001		1,646						26
27			2001		1,180						27
28	Day Room Carpet										28
29	Hot Water Heater		2002		1,225						29
30	Sewar repair		2002		2,224						30
31			2002		1,965						31
32											32
33											33
34	C/O Allocation							17,052	17,052		34
35	Book Depreciation					111,255		111,255		1,122,913	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-Pana

0041533

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		
37		\$	\$		\$	\$	\$	37	
38	Sealcoat Parking Lot	2003	3,338					38	
39	A/C unit	2003	1,153					39	
40	Key Service Unit	2003	1,063					40	
41	Carpeting	2003	5,655					41	
42	Ansul System	2003	1,803					42	
43								43	
44	Booster Heater	2004	1,151					44	
45	Energy Mgt System	2004	12,890					45	
46	Exterior Doors	2004	1,247					46	
47	Heat/Cool Units	2004	7,372					47	
48	Drive way repairs	2004	1,765					48	
49	Carpeting	2004	13,652					49	
50	Sewer Replacement	2004	2,847					50	
51								51	
52	Heat/Cool Units	2005	13,286					52	
53	Underfloor Ductwork	2005	1,100					53	
54	Sidewalks	2005	9,208					54	
55	Roof	2005	4,161					55	
56								56	
57	Sewer Replacement	2006	13,522					57	
58	A/C unit	2006	5,660					58	
59	Resident Room Carpet	2006	11,370					59	
60	Parking Lot Resurface	2006	47,908					60	
61	Remodel Dinning Room	2006	4,854					61	
62	Fire Alarm Panel	2006	531					62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)		\$ 4,270,634	\$ 111,255		\$ 128,307	\$ 17,052	\$ 1,122,913	70

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

Facility Name & ID Number Heritage Manor-Pana

0041533

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		\$ 4,270,634	\$ 111,255		\$ 128,307	\$ 17,052	\$ 1,122,913	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,270,634	\$ 111,255		\$ 128,307	\$ 17,052	\$ 1,122,913	34

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

Facility Name & ID Number Heritage Manor-Pana

0041533

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 12B, Carried Forward		\$ 4,270,634	\$ 111,255		\$ 128,307	\$ 17,052	\$ 1,122,913	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,270,634	\$ 111,255		\$ 128,307	\$ 17,052	\$ 1,122,913	34

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

Facility Name & ID Number Heritage Manor-Pana # 0041533 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	\$ 441,318	\$ 21,775	\$ 21,775	\$		\$ 392,171	71
72	Current Year Purchases	98,632						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 539,950	\$ 21,775	\$ 21,775	\$		\$ 392,171	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,861,639	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 133,030	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 150,082	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,052	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,515,084	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.

Facility Name & ID Number Heritage Manor-Pana

0041533

Report Period Beginning: 01/01/06

Ending: 12/31/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /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: \$ 24,772 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		231		231
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	\$	\$ 231	\$	\$ 231
10	SUM OF line 9, col. 1 and 2 (e)	\$	231		

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Heritage Manor-Pana# 0041533

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	\$		\$ 187,378	\$		\$ 187,378	1
2	Licensed Speech and Language Development Therapist		hrs			124,474			124,474	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			220,178	1,361		221,539	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				603,407		603,407	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					32,824			32,824	13
14	TOTAL			\$		\$ 564,854	\$ 604,768		\$ 1,169,622	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-Pana# 0041533Report 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	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,320	\$	1
2	Cash-Patient Deposits	16,916		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	810,195		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,922		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,322,836		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,171,189	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	51,055		13
14	Buildings, at Historical Cost	4,270,635		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	539,950		16
17	Accumulated Depreciation (book methods)	(1,515,084)		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>	21,258		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,367,814	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,539,003	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 184,323	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,916		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	325,251		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,201		31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,483		32
33	Accrued Interest Payable	15,061		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 614,235	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,874,390		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deposits</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,874,390	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,488,625	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,050,378	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,539,003	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,657,902	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,657,902	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	392,476	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 392,476	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,050,378	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Pana# 0041533Report 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,066,011	1
2	Discounts and Allowances for all Levels	(2,584,192)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,481,819	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,054,673	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,054,673	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	6,739	12
13	Barber and Beauty Care	24,385	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	659,989	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,338	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 694,451	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	56	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 56	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,230,999	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	966,549	31
32	Health Care	2,949,691	32
33	General Administration	1,427,974	33
B. Capital Expense			
34	Ownership	468,875	34
C. Ancillary Expense			
35	Special Cost Centers	25,434	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	Non Nursing Home Expenses		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,838,523	40
41	Income before Income Taxes (line 30 minus line 40)**	392,476	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 392,476	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-Pana

0041533

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	1,936	2,078	\$ 61,784	\$ 29.73	1
2	Assistant Director of Nursing	3,011	3,436	66,333	19.31	2
3	Registered Nurses	4,823	5,078	121,919	24.01	3
4	Licensed Practical Nurses	20,341	21,894	354,613	16.20	4
5	CNAs & Orderlies	111,213	121,661	1,132,902	9.31	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,820	3,169	43,949	13.87	8
9	Activity Director					9
10	Activity Assistants	5,065	5,860	54,843	9.36	10
11	Social Service Workers	4,349	4,969	69,723	14.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,440	24,202	222,557	9.20	15
16	Dishwashers					16
17	Maintenance Workers	5,194	5,666	85,535	15.10	17
18	Housekeepers	9,183	10,071	88,182	8.76	18
19	Laundry	10,231	11,096	78,945	7.11	19
20	Administrator	1,950	2,080	85,168	40.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,087	9,160	123,783	13.51	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)	210,643	230,420	\$ 2,590,236 *	\$ 11.24	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		16,800		36
37	Medical Records Consultant		944		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,530		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		3,135		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,409		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. \$ 82,673
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. \$ 3,100
- (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	Code	Description	Unit	Quantity	Unit Price	Total Price
1001	01	1001				
1002	02	1002				
1003	03	1003				
1004	04	1004				
1005	05	1005				
1006	06	1006				
1007	07	1007				
1008	08	1008				
1009	09	1009				
1010	10	1010				
1011	11	1011				
1012	12	1012				
1013	13	1013				
1014	14	1014				
1015	15	1015				
1016	16	1016				
1017	17	1017				
1018	18	1018				
1019	19	1019				
1020	20	1020				
1021	21	1021				
1022	22	1022				
1023	23	1023				
1024	24	1024				
1025	25	1025				
1026	26	1026				
1027	27	1027				
1028	28	1028				
1029	29	1029				
1030	30	1030				
1031	31	1031				
1032	32	1032				
1033	33	1033				
1034	34	1034				
1035	35	1035				
1036	36	1036				
1037	37	1037				
1038	38	1038				
1039	39	1039				
1040	40	1040				
1041	41	1041				
1042	42	1042				
1043	43	1043				
1044	44	1044				
1045	45	1045				
1046	46	1046				
1047	47	1047				
1048	48	1048				
1049	49	1049				
1050	50	1050				
1051	51	1051				
1052	52	1052				
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1062	62	1062				
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1067	67	1067				
1068	68	1068				
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1074	74	1074				
1075	75	1075				
1076	76	1076				
1077	77	1077				
1078	78	1078				
1079	79	1079				
1080	80	1080				
1081	81	1081				
1082	82	1082				
1083	83	1083				
1084	84	1084				
1085	85	1085				
1086	86	1086				
1087	87	1087				
1088	88	1088				
1089	89	1089				
1090	90	1090				
1091	91	1091				
1092	92	1092				
1093	93	1093				
1094	94	1094				
1095	95	1095				
1096	96	1096				
1097	97	1097				
1098	98	1098				
1099	99	1099				
1100	100	1100				

Code	Description	Unit	Quantity	Unit Price	Total Price
1101	1101				
1102	1102				
1103	1103				
1104	1104				
1105	1105				
1106	1106				
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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	374,958	10	0 Salary	22,895	ine 17, col 1	#REF!	417,825	417,825		19,972	397,853	22,895
#REF!	Craig Hart	Chairman	0	447,392	10	0 Salary	27,317	ine 17, col 1	#REF!	498,540	498,540		23,831	474,709	27,317
#REF!	Cheryl Lov	Executive	0	255,965	50	1 Salary	15,629	ine 17, col 1	#REF!	285,228	285,228		13,634	271,594	15,629
#REF!	Steve War	President	0	334,857	50	1 Salary	20,446	ine 17, col 1	#REF!	373,139	373,139		17,836	355,303	20,446
#REF!	Connie Ho	Sr Vice Pres	0	167,404	40	1 Salary	10,222	ine 17, col 1	#REF!	186,543	186,543		8,917	177,626	10,222
#REF!	Craig Ater	Sr Vice Pres	0	188,713	50	1 Salary	11,523	ine 17, col 1	#REF!	210,288	210,288		10,052	200,236	11,523
	Ben Hart	Vice Pres		82,989			5,067			92,476	92,476		4,420	88,056	5,067
13				1,852,278		TOTAL	113,099		13	2,064,039	2,064,039			1,965,377	113,099

* 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
108,032 #####

**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

