

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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 License ID Number:** 0048066

**Facility Name:** Heritage Manor Streator

**Address:** 1525 East Main Street Streator 61364  
 Number City Zip Code

**County:** LsSalle

**Telephone Number:** ( 815 ) 672-4516 Fax # ( )

**HFS ID Number:** 203902216001

**Date of Initial License for Current Owners:** 07/2006

**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 01/01/07 to 12/31/07 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) _____	<u>04/15/08</u>
	(Type or Print Name) <u>Craig Ater</u>	(Date)
<b>Paid Preparer</b>	(Title) <u>Sr. VP &amp; CFO</u>	
	(Signed) _____	(Date)
<b>Paid Preparer</b>	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____	Fax # ( ) _____
	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>	

Phone # (217) 782-1630

Facility Name & ID Number Heritage Manor Streator# 0048066 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</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>22,414</u>	<u>15,547</u>	<u>4,329</u>	<u>42,290</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,414</u>	<u>15,547</u>	<u>4,329</u>	<u>42,290</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.55%

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)  
\_\_\_\_\_F. Does the facility maintain a daily midnight census? yes

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

YES  NO 

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

YES  NO 

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

Date started 07/2006

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

YES  Date 07/2006 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 4,329Medicare Intermediary WPS

## IV. ACCOUNTING BASIS

ACCRAUAL  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 Streator # 0048066 Report Period Beginning: 01/01/07 Ending: 12/31/07

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	246,413	15,923		262,336		262,336	6,510	268,846		1
2	Food Purchase		220,553		220,553		220,553	26	220,579		2
3	Housekeeping	107,951	15,199		123,150		123,150		123,150		3
4	Laundry	45,094	17,787		62,881		62,881		62,881		4
5	Heat and Other Utilities			106,827	106,827		106,827	1,855	108,682		5
6	Maintenance	85,032	67,296	32,248	184,576		184,576	14,712	199,288		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>484,490</b>	<b>336,758</b>	<b>139,075</b>	<b>960,323</b>		<b>960,323</b>	<b>23,103</b>	<b>983,426</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			800	800		800	2,330	3,130		9
10	Nursing and Medical Records	1,924,760	145,877	8,047	2,078,684		2,078,684		2,078,684		10
10a	Therapy		314,547	358,545	673,092	(332,925)	340,167	230,927	571,094		10a
11	Activities	82,488	5,130		87,618		87,618	1,694	89,312		11
12	Social Services	24,459	16	2,737	27,212		27,212		27,212		12
13	CNA Training	7,058	400		7,458		7,458	2,157	9,615		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,038,765</b>	<b>465,970</b>	<b>370,129</b>	<b>2,874,864</b>	<b>(332,925)</b>	<b>2,541,939</b>	<b>237,108</b>	<b>2,779,047</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	84,859			84,859		84,859	77,208	162,067		17
18	Directors Fees							6,870	6,870		18
19	Professional Services			293,927	293,927		293,927	(284,271)	9,656		19
20	Dues, Fees, Subscriptions & Promotions			105,964	105,964	(65,700)	40,264	(13,572)	26,692		20
21	Clerical & General Office Expenses	142,565	21,662	9,708	173,935		173,935	169,500	343,435		21
22	Employee Benefits & Payroll Taxes			517,938	517,938		517,938	46,420	564,358		22
23	Inservice Training & Education			1,518	1,518		1,518	481	1,999		23
24	Travel and Seminar			5,219	5,219		5,219	(3,220)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			81,753	81,753		81,753	6,843	88,596		26
27	Other (specify):*			1,129	1,129		1,129	(1,129)			27
28	<b>TOTAL General Administration</b>	<b>227,424</b>	<b>21,662</b>	<b>1,017,156</b>	<b>1,266,242</b>	<b>(65,700)</b>	<b>1,200,542</b>	<b>5,130</b>	<b>1,205,672</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,750,679</b>	<b>824,390</b>	<b>1,526,360</b>	<b>5,101,429</b>	<b>(398,625)</b>	<b>4,702,804</b>	<b>265,341</b>	<b>4,968,145</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 Streator

#0048066

Report Period Beginning:

01/01/07

Ending:

12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			207,864	207,864		207,864	11,877	219,741			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			326,567	326,567		326,567	6,335	332,902			32
33	Real Estate Taxes			71,142	71,142		71,142		71,142			33
34	Rent-Facility & Grounds							7,252	7,252			34
35	Rent-Equipment & Vehicles			5,599	5,599		5,599	1,974	7,573			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			611,172	611,172		611,172	27,438	638,610			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					332,925	332,925		332,925			39
40	Barber and Beauty Shops		949	15,703	16,652		16,652		16,652			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					65,700	65,700		65,700			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		949	15,703	16,652	398,625	415,277		415,277			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,750,679	825,339	2,153,235	5,729,253		5,729,253	292,779	6,022,032			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 Streator

# 0048066

Report Period Beginning: 01/01/07

Ending: 12/31/07

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(1,690)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,596)	20		17
18	Fines and Penalties				18
19	Entertainment	(14,378)	24		19
20	Contributions	(1,129)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(7,127)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(19,287)	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>	\$ (45,207)		\$	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)	337,986		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 337,986		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 292,779		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 Streater

ID# 0048066

Report Period Beginning: 01/01/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(1,596)	20
18			18
19			24
20		(1,129)	27
21			21
22		(7,127)	19
23			23
24		0	27
25		(19,287)	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>	(29,139)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor Streator

# 0048066

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	6,510	0	0	0	0	0	0	0	0	6,510	1
2	Food Purchase	0	0	26	0	0	0	0	0	0	0	0	26	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,855	0	0	0	0	0	0	0	0	1,855	5
6	Maintenance	0	0	14,712	0	0	0	0	0	0	0	0	14,712	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	23,103	0	0	0	0	0	0	0	0	23,103	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	2,330	0	0	0	0	0	0	0	0	2,330	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	230,927	0	0	0	0	0	0	0	0	0	230,927	10a
11	Activities	0	0	1,694	0	0	0	0	0	0	0	0	1,694	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	2,157	0	0	0	0	0	0	0	0	2,157	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	230,927	6,181	0	0	0	0	0	0	0	0	237,108	16
	<b>C. General Administration</b>													
17	Administrative	0	0	77,208	0	0	0	0	0	0	0	0	77,208	17
18	Directors Fees	0	0	6,870	0	0	0	0	0	0	0	0	6,870	18
19	Professional Services	(7,127)	(286,800)	9,656	0	0	0	0	0	0	0	0	(284,271)	19
20	Fees, Subscriptions & Promotions	(20,883)	0	7,311	0	0	0	0	0	0	0	0	(13,572)	20
21	Clerical & General Office Expenses	0	0	169,500	0	0	0	0	0	0	0	0	169,500	21
22	Employee Benefits & Payroll Taxes	0	0	46,420	0	0	0	0	0	0	0	0	46,420	22
23	Inservice Training & Education	0	0	481	0	0	0	0	0	0	0	0	481	23
24	Travel and Seminar	(14,378)	0	11,158	0	0	0	0	0	0	0	0	(3,220)	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	6,843	0	0	0	0	0	0	0	0	6,843	26
27	Other (specify):*	(1,129)	0	0	0	0	0	0	0	0	0	0	(1,129)	27
28	<b>TOTAL General Administration</b>	(43,517)	(286,800)	335,447	0	0	0	0	0	0	0	0	5,130	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(43,517)	(55,873)	364,731	0	0	0	0	0	0	0	0	265,341	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Streator

# 0048066

Report Period Beginning:

01/01/07 Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	11,877	0	0	0	0	0	0	0	11,877	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,690)	0	0	8,025	0	0	0	0	0	0	0	6,335	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	7,252	0	0	0	0	0	0	0	7,252	34
35	Rent-Equipment & Vehicles	0	0	0	1,974	0	0	0	0	0	0	0	1,974	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,690)</b>	<b>0</b>	<b>0</b>	<b>29,128</b>	<b>0</b>	<b>27,438</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>(45,207)</b>	<b>(55,873)</b>	<b>364,731</b>	<b>29,128</b>	<b>0</b>	<b>292,779</b>	<b>45</b>						

Facility Name & ID Number Heritage Manor Streator

# 0048066

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	286,800	Heritage Enterprises, Inc.			(286,800)	4
5	V							5
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		230,927	230,927	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 286,800			\$ 230,927	\$ * (55,873)	14

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

Facility Name & ID Number Heritage Manor Streator# 0048066Report Period Beginning: 01/01/07Ending: 12/31/07**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%	\$	6,510	15
16	V	2 Food Purchase					26	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,855	19
20	V	6 Maintenance					14,712	20
21	V	7 Other					0	21
22	V	9 Medical Director					2,330	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					1,694	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					2,157	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					77,208	29
30	V	18 Directors Fees					6,870	30
31	V	19 Professional Services					9,656	31
32	V	20 Fees, Subscription, Promotions					7,311	32
33	V	21 Clerical & General Office Expenses					169,500	33
34	V	22 Employee Benefits & Payroll Taxes					46,420	34
35	V	23 Inservice Training & Education					481	35
36	V	24 Travel and Seminar					11,158	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					6,843	38
39	Total		\$			\$	0	\$ * 364,731 39

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

Facility Name & ID Number Heritage Manor Streator# 0048066Report Period Beginning: 01/01/07Ending: 12/31/07**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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	27	Other	\$		100.00%	\$	0	15
16	V	30	Depreciation					11,877	16
17	V	31	Amortization of Pre-Op & Org						17
18	V	32	Interest					8,025	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					7,252	20
21	V	35	Rent-Equipment & Vehicles					1,974	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			\$			\$	0	\$ * 29,128 39

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

Facility Name & ID Number Heritage Manor Streator # 0048066 Report Period Beginning: 01/01/07 Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises, Inc.	Member		100.00					\$ 6,870	Line 18	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,870		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 Streator

# 0048066

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Heritage Operations Group  
 Street Address box 3188  
 City / State / Zip Code Bloomington, IL 61701  
 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	\$ 142,342	\$ 142,057	120	\$ 6,510	1
2	2	Food Purchase	Beds	2,624	25	577	0	120	26	2
3	3	Housekeeping	Beds	2,624	25	0	0	120	0	3
4	4	Laundry	Beds	2,624	25	0	0	120	0	4
5	5	Heat & Other Utilities	Beds	2,624	25	40,565	0	120	1,855	5
6	6	Maintenance	Beds	2,624	25	321,709	65,509	120	14,712	6
7	7	Other	Beds	2,624	25	0	0	120	0	7
8	9	Medical Director	Beds	2,624	25	50,960	0	120	2,330	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	56,488	120	0	9
10	11	Activities	Beds	2,624	25	37,038	36,931	120	1,694	10
11	12	Social Service	Beds	2,624	25	0	0	120	0	11
12	13	Nurse Aide Training	Beds	2,624	25	47,168	47,168	120	2,157	12
13	14	Program Transportation	Beds	2,624	25	0	0	120	0	13
14	15	Other	Beds	2,624	25	0	0	120	0	14
15	17	Administrative	Beds	2,624	25	1,688,288	1,688,288	120	77,208	15
16	18	Directors Fees	Beds	2,624	25	150,218	0	120	6,870	16
17	19	Professional Services	Beds	2,624	25	211,148	0	120	9,656	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	159,872	0	120	7,311	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,706,408	3,356,042	120	169,500	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	1,015,049	0	120	46,420	20
21	23	Inservice Training & Education	Beds	2,624	25	10,511	0	120	481	21
22	24	Travel and Seminar	Beds	2,624	25	243,988	0	120	11,158	22
23	25	Other Admin. Staff Transportatio	Beds	2,624	25	0	0	120	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,624	25	149,629	0	120	6,843	24
25	TOTALS					\$ 7,975,470	\$ 5,392,483		\$ 364,731	25

Facility Name & ID Number Heritage Manor Streator

# 0048066

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$	120	\$	1
2	30	Depreciation	Beds	2,624	25	259,703	120	11,877	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		120		3
4	32	Interest	Beds	2,624	25	175,477	120	8,025	4
5	33	Real Estate Taxes	Beds	2,624	25		120		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587	120	7,252	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166	120	1,974	7
8	36	Other	Beds	2,624	25		120		8
9	38	Medically Nec Transportation	Beds	2,624	25		120		9
10	39	Ancillary Service Centers	Beds	2,624	25		120		10
11	40	Barber and Beauty Shops	Beds	2,624	25		120		11
12	41	Coffee and Gift Shops	Beds	2,624	25		120		12
13	42	Other	Beds	2,624	25		120		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					\$ 636,933	\$	\$ 29,128	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	LsSalle National Bank		xx	Mortgage			\$	\$ 3,571,318		\$ 300,235	1									
2	LsSalle National Bank		xx	Mortgage						9,804	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	LsSalle National Bank		xx	Working Capital						16,528	6									
7	LsSalle National Bank		xx								7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$ 3,571,318		\$ 326,567	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income									(1,690)	10									
11	Allocated Corporate									8,025	11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ 6,335	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 3,571,318		\$ 332,902	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 2006 report.		\$	<u>54,283</u>	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.)		\$	<u>62,265</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>7,982</u>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>63,160</u>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>71,142</u>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	<u>45,769</u>	8	
	2003	<u>46,194</u>	9	
	2004	<u>45,092</u>	10	
	2005	<u>57,575</u>	11	
	2006	<u>71,142</u>	12	
				<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor Streator COUNTY LsSalle

FACILITY IDPH LICENSE NUMBER 0048066

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 2006 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 2006.

(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>34-31-129-000</u>	<u>Nursing Home</u>	\$ <u>2,474.00</u>	\$ <u>2,474.00</u>
2. <u>34-31-112-000</u>	<u></u>	\$ <u>57,679.00</u>	\$ <u>57,678.00</u>
3. <u>34-31-112-000</u>	<u></u>	\$ <u>2,113.00</u>	\$ <u>2,113.00</u>
4. <u></u>	<u></u>	\$ _____	\$ _____
5. <u></u>	<u></u>	\$ _____	\$ _____
6. <u></u>	<u></u>	\$ _____	\$ _____
7. <u></u>	<u></u>	\$ _____	\$ _____
8. <u></u>	<u></u>	\$ _____	\$ _____
9. <u></u>	<u></u>	\$ _____	\$ _____
10. <u></u>	<u></u>	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>62,266.00</u>	\$ <u>62,265.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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 Streator

# 0048066 Report Period Beginning:

01/01/07 Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 19,262 B. General Construction Type: Exterior brick 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>17,000</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>17,000</u>	3

Facility Name &amp; ID Number Heritage Manor Streator

# 0048066

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1964	1964	\$ 348,848	\$		\$	\$	\$	4
5			1964	1964	440,122						5
6			2006	2006	2,594,839						6
7											7
8											8
		<b>Improvement Type**</b>									
9		1978 Improvements		1980	12,172						9
10		1979 Improvements		1981	13,748						10
11		1980 Improvements		1982	18,366						11
12		1981 Improvements		1983	9,250						12
13		1982 Improvements		1984	1,329						13
14		1983 Improvements		1985	4,100						14
15		1984 Improvements		1986	57,336						15
16		1985 Improvements		1987	6,225						16
17		1986 Improvements		1988	48,818						17
18		1988 Improvements		1989	22,687						18
19		1989 Improvements		1990	31,584						19
20		1990 Improvements		1991	3,560						20
21		1991 Improvements		1992	19,172						21
22		1992 Improvements		1993	23,135						22
23		1993 Improvements		1994	22,036						23
24		1994 Improvements		1995	39,228						24
25		1995 Improvements		1996	3,910						25
26		BOILER									26
27		EXHAUST HOOD									27
28		CODE ALERT									28
29		PHONE SYSTEM									29
30		INTERIOR REMODEL									30
31											31
32											32
33											33
34		C/O Allocation						11,877	11,877		34
35		Book Depreciation				150,243		150,243		968,968	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 Streator# 0048066

Report Period Beginning:

01/01/07

Ending:

12/31/07**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	Interior Rehab---Facility	1997	\$ 286,974	\$		\$	\$	\$	37
38	Roof	1997	5,232						38
39	Sprinkler System	1997	9,530						39
40	Code Alert	1997	1,879						40
41									41
42	Code Alert	1998	2,000						42
43	Bathroom Door	1998	656						43
44	Interior Rehab	1998	11,815						44
45									45
46	Door Alarms	1999	3,675						46
47									47
48	Water Heater	2000	4,114						48
49	Exhaust Fans	2000	931						49
50	Booster Heater -- Water Heater	2000	1,465						50
51									51
52	Professional Fees---Building Renovation	2001	27,964						52
53	Sprinkler Replacement	2001	4,955						53
54	AC Unit with Installation	2001	4,372						54
55	Exterior Painting	2001	6,545						55
56	Code Alert System	2001	4,592						56
57									57
58	Roof	2002	48,840						58
59	Sewer line	2002	20,615						59
60	Condensing Unit	2002	1,213						60
61									61
62	Exterior Door	2003	6,556						62
63	Exit Lights	2003	1,013						63
64	Heating Pump	2003	1,746						64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 4,177,147	\$ 150,243		\$ 162,120	\$ 11,877	\$ 968,968	70

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

Facility Name &amp; ID Number Heritage Manor Streator

# 0048066

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,177,147	\$ 150,243		\$ 162,120	\$ 11,877	\$ 968,968	1
2	Doors								2
3	A/C	2004	1,386						3
4	PVC kickplate	2004	5,061						4
5	Disposal	2004	2,859						5
6		2004	1,175						6
7	Roof								7
8	A/C Condensing Unit	2005	54,596						8
9	Window Replacement	2005	5,800						9
10	Water Main	2005	51,893						10
11		2005	1,706						11
12									12
13	Roof								13
14	A/C Replacement	2006	19,500						14
15	Boiler	2006	1,974						15
16	Landscapping	2006	58,327						16
17		2006	5,398						17
18									18
19	Nurse's station	2007	9,580						19
20	Nurse call system	2007	96,193						20
21	Wireless network	2007	26,272						21
22	Corridor Paint and floors	2007	37,819						22
23	A/C	2007	23,747						23
24	Wander guard	2007	4,177						24
25	Garage	2007	42,453						25
26	Professional Fee -- remodel	2007	1,286						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,628,349	\$ 150,243		\$ 162,120	\$ 11,877	\$ 968,968	34

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

Facility Name & ID Number Heritage Manor Streator

# 0048066

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	\$ 4,628,349	\$ 150,243		\$ 162,120	\$ 11,877	\$ 968,968		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)	\$ 4,628,349	\$ 150,243		\$ 162,120	\$ 11,877	\$ 968,968		34

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

Facility Name & ID Number Heritage Manor Streator # 0048066 Report Period Beginning: 01/01/07 Ending: 12/31/07

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	\$ 992,363	\$ 57,621	\$ 57,621	\$		\$ 742,168	71
72	Current Year Purchases	50,974						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,043,337	\$ 57,621	\$ 57,621	\$		\$ 742,168	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 Description	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)	\$ 5,688,686	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 207,864	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 219,741	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,877	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,711,136	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: Heritage Manor Real Estate, LLC.

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:		120		\$ 262,800	5		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		120		\$ 262,800			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.	<u>/2008</u>	\$ <u>262,800</u>
13.	<u>/2009</u>	\$ <u>262,800</u>
14.	<u>/2010</u>	\$ <u>262,800</u>

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: \$ 7,573 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		400		400
3	Classroom Wages (a)		7,058		7,058
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 7,458	\$	\$ 7,458
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	7,458		

**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 Streator# 0048066 Report Period Beginning:01/01/07 Ending:12/31/07

## 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	\$		\$ 128,270	\$		\$ 128,270	1
2	Licensed Speech and Language Development Therapist		hrs			36,020			36,020	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			174,278	1,599		175,877	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				312,948		312,948	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					19,977			19,977	13
14	<b>TOTAL</b>			\$		\$ 358,545	\$ 314,547		\$ 673,092	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 Streator# 0048066Report Period Beginning: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 47,014	\$	1
2	Cash-Patient Deposits	6,154		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	717,398		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,626		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(506,429)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 293,763	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	4,467,009		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,017,567		16
17	Accumulated Depreciation (book methods)	(1,711,136)		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):	35,609		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,859,049	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,152,812	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 199,672	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,154		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	258,301		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,744		31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,160		32
33	Accrued Interest Payable			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>	\$ 560,031	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,571,318		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,571,318	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,131,349	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 21,463	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,152,812	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 150,260	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 150,260	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	621,203	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	(750,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (128,797)</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 21,463</b>	24 *

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

Facility Name & ID Number Heritage Manor Streator# 0048066Report Period Beginning: 01/01/07Ending: 12/31/07**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	\$ 6,147,385	1
2	Discounts and Allowances for all Levels	(1,589,711)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,557,674</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,210,978	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,210,978</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	5,336	11
12	Gift and Coffee Shop	1,140	12
13	Barber and Beauty Care	22,094	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	546,418	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,126	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 580,114</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,690	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,690</b>	<b>26</b>
<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>		<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,350,456</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	960,323	31
32	Health Care	2,874,864	32
33	General Administration	1,266,242	33
<b>B. Capital Expense</b>			
34	Ownership	611,172	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	16,652	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 5,729,253</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>621,203</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 621,203</b>	<b>43</b>

\* 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 Streator

# 0048066

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	1,844	2,087	\$ 56,030	\$ 26.85	1
2	Assistant Director of Nursing	1,859	2,080	47,006	22.60	2
3	Registered Nurses	11,125	12,104	272,919	22.55	3
4	Licensed Practical Nurses	16,948	18,426	393,682	21.37	4
5	CNAs & Orderlies	92,491	99,285	1,117,224	11.25	5
6	CNA Trainees	750	750	7,058	9.41	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,810	3,152	37,899	12.02	8
9	Activity Director					9
10	Activity Assistants	7,454	8,477	82,488	9.73	10
11	Social Service Workers	1,899	2,101	24,459	11.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,835	27,687	246,413	8.90	15
16	Dishwashers					16
17	Maintenance Workers	6,043	6,726	85,032	12.64	17
18	Housekeepers	12,056	12,835	107,951	8.41	18
19	Laundry	4,248	4,835	45,094	9.33	19
20	Administrator	1,900	2,080	84,859	40.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,090	10,303	142,565	13.84	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)	196,352	212,928	\$ 2,750,679 *	\$ 12.92	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		800		36
37	Medical Records Consultant		200		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,300		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		2,737		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 7,037		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	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? \_\_\_\_\_  
What was the average life used for new equipment added during this period? \_\_\_\_\_
- (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 xx NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Heritage Manor Streator 38349 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,700  
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. \$ 4,929
- (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? \_\_\_\_\_ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_
- 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 date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.



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