

		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:** 0048157

**Facility Name:** Heritage Manor-Bloomington

**Address:** 700 E. Walnut Street Bloomington 61701  
 Number City Zip Code

**County:** McLean

**Telephone Number:** ( 309 ) 827-8004 Fax # ( )

**HFS ID Number:** 203904134001

**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-Bloomington# 0048157 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>111</u>	Skilled (SNF)	<u>111</u>	<u>40,515</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>111</u>	TOTALS	<u>111</u>	<u>40,515</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>18,049</u>	<u>7,871</u>	<u>5,074</u>	<u>30,994</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>18,049</u>	<u>7,871</u>	<u>5,074</u>	<u>30,994</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.50%

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 1963

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 5,074Medicare 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-Bloomington # 0048157 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	238,514	26,698		265,212		265,212	6,021	271,233		1
2	Food Purchase		182,543		182,543		182,543	24	182,567		2
3	Housekeeping	70,338	24,451		94,789		94,789		94,789		3
4	Laundry	67,786	16,238		84,024		84,024		84,024		4
5	Heat and Other Utilities			120,656	120,656		120,656	1,716	122,372		5
6	Maintenance	109,316	38,409	50,631	198,356		198,356	13,609	211,965		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>485,954</b>	<b>288,339</b>	<b>171,287</b>	<b>945,580</b>		<b>945,580</b>	<b>21,370</b>	<b>966,950</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000	2,156	14,156		9
10	Nursing and Medical Records	1,614,694	173,372	264,002	2,052,068		2,052,068		2,052,068		10
10a	Therapy		336,247	660,081	996,328	(370,810)	625,518	215,831	841,349		10a
11	Activities	64,743	2,275		67,018		67,018	1,567	68,585		11
12	Social Services	32,114		3,954	36,068		36,068		36,068		12
13	CNA Training	8,752	1,925		10,677		10,677	1,995	12,672		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,720,303</b>	<b>513,819</b>	<b>940,037</b>	<b>3,174,159</b>	<b>(370,810)</b>	<b>2,803,349</b>	<b>221,549</b>	<b>3,024,898</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	61,055			61,055		61,055	71,418	132,473		17
18	Directors Fees							6,354	6,354		18
19	Professional Services			215,811	215,811		215,811	(206,879)	8,932		19
20	Dues, Fees, Subscriptions & Promotions			146,867	146,867	(60,773)	86,094	(11,700)	74,394		20
21	Clerical & General Office Expenses	166,881	23,548	18,903	209,332		209,332	156,788	366,120		21
22	Employee Benefits & Payroll Taxes			594,453	594,453		594,453	42,938	637,391		22
23	Inservice Training & Education			1,554	1,554		1,554	445	1,999		23
24	Travel and Seminar			3,691	3,691		3,691	(1,692)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			78,330	78,330		78,330	6,330	84,660		26
27	Other (specify):*			49,088	49,088		49,088	(49,000)	88		27
28	<b>TOTAL General Administration</b>	<b>227,936</b>	<b>23,548</b>	<b>1,108,697</b>	<b>1,360,181</b>	<b>(60,773)</b>	<b>1,299,408</b>	<b>15,002</b>	<b>1,314,410</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,434,193</b>	<b>825,706</b>	<b>2,220,021</b>	<b>5,479,920</b>	<b>(431,583)</b>	<b>5,048,337</b>	<b>257,921</b>	<b>5,306,258</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-Bloomington

#0048157

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			156,047	156,047		156,047	10,986	167,033			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			185,006	185,006		185,006	4,523	189,529			32
33	Real Estate Taxes			75,339	75,339		75,339		75,339			33
34	Rent-Facility & Grounds							6,709	6,709			34
35	Rent-Equipment & Vehicles			3,636	3,636		3,636	1,826	5,462			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			420,028	420,028		420,028	24,044	444,072			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					370,810	370,810		370,810			39
40	Barber and Beauty Shops			12,686	12,686		12,686		12,686			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,773	60,773		60,773			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			12,686	12,686	431,583	444,269		444,269			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,434,193	825,706	2,652,735	5,912,634		5,912,634	281,965	6,194,599			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-Bloomington

# 0048157

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	(2,900)	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	(533)	20		17
18	Fines and Penalties				18
19	Entertainment	(12,013)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,540)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,000)	27		24
25	Fund Raising, Advertising and Promotional	(17,930)	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>	\$ (83,916)		\$	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)	365,881		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 365,881		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 281,965		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-Bloomington

ID# 0048157

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		(533)	20
18			18
19			24
20		0	27
21			21
22		(1,540)	19
23			23
24		(49,000)	27
25		(17,930)	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>	(69,003)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Bloomington

# 0048157

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	6,021	0	0	0	0	0	0	0	0	6,021	1
2	Food Purchase	0	0	24	0	0	0	0	0	0	0	0	24	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	1,716	0	0	0	0	0	0	0	0	1,716	5
6	Maintenance	0	0	13,609	0	0	0	0	0	0	0	0	13,609	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	21,370	0	0	0	0	0	0	0	0	21,370	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	2,156	0	0	0	0	0	0	0	0	2,156	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	215,831	0	0	0	0	0	0	0	0	0	215,831	10a
11	Activities	0	0	1,567	0	0	0	0	0	0	0	0	1,567	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,995	0	0	0	0	0	0	0	0	1,995	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	215,831	5,718	0	0	0	0	0	0	0	0	221,549	16
	<b>C. General Administration</b>													
17	Administrative	0	0	71,418	0	0	0	0	0	0	0	0	71,418	17
18	Directors Fees	0	0	6,354	0	0	0	0	0	0	0	0	6,354	18
19	Professional Services	(1,540)	(214,271)	8,932	0	0	0	0	0	0	0	0	(206,879)	19
20	Fees, Subscriptions & Promotions	(18,463)	0	6,763	0	0	0	0	0	0	0	0	(11,700)	20
21	Clerical & General Office Expenses	0	0	156,788	0	0	0	0	0	0	0	0	156,788	21
22	Employee Benefits & Payroll Taxes	0	0	42,938	0	0	0	0	0	0	0	0	42,938	22
23	Inservice Training & Education	0	0	445	0	0	0	0	0	0	0	0	445	23
24	Travel and Seminar	(12,013)	0	10,321	0	0	0	0	0	0	0	0	(1,692)	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	6,330	0	0	0	0	0	0	0	0	6,330	26
27	Other (specify):*	(49,000)	0	0	0	0	0	0	0	0	0	0	(49,000)	27
28	<b>TOTAL General Administration</b>	(81,016)	(214,271)	310,289	0	0	0	0	0	0	0	0	15,002	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(81,016)	1,560	337,377	0	0	0	0	0	0	0	0	257,921	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

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	10,986	0	0	0	0	0	0	0	10,986	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,900)	0	0	7,423	0	0	0	0	0	0	0	4,523	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	6,709	0	0	0	0	0	0	0	6,709	34
35	Rent-Equipment & Vehicles	0	0	0	1,826	0	0	0	0	0	0	0	1,826	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,900)</b>	<b>0</b>	<b>0</b>	<b>26,944</b>	<b>0</b>	<b>24,044</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>(83,916)</b>	<b>1,560</b>	<b>337,377</b>	<b>26,944</b>	<b>0</b>	<b>281,965</b>	<b>45</b>						

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

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		\$			\$	\$
2	V	10a Adjustment for Related Organization					
3	V						
4	V	19 Adjustment for Related Organization	214,271	Heritage Enterprises, Inc.			(214,271)
5	V						
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		215,831	215,831
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 214,271			\$ 215,831	\$ * 1,560

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

Facility Name & ID Number Heritage Manor-Bloomington# 0048157Report 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%	\$	6,021	15
16	V	2 Food Purchase					24	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,716	19
20	V	6 Maintenance					13,609	20
21	V	7 Other					0	21
22	V	9 Medical Director					2,156	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					1,567	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,995	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					71,418	29
30	V	18 Directors Fees					6,354	30
31	V	19 Professional Services					8,932	31
32	V	20 Fees, Subscription, Promotions					6,763	32
33	V	21 Clerical & General Office Expenses					156,788	33
34	V	22 Employee Benefits & Payroll Taxes					42,938	34
35	V	23 Inservice Training & Education					445	35
36	V	24 Travel and Seminar					10,321	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					6,330	38
39	Total		\$			\$	0	\$ * 337,377 39

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

Facility Name & ID Number Heritage Manor-Bloomington# 0048157Report 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					10,986	16
17	V	31	Amortization of Pre-Op & Org						17
18	V	32	Interest					7,423	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,709	20
21	V	35	Rent-Equipment & Vehicles					1,826	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	\$ * 26,944 39

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

Facility Name & ID Number Heritage Manor-Bloomington # 0048157 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					\$ 6,354	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	\$ 6,354		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-Bloomington

# 0048157

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	111	\$ 6,021	1
2	2	Food Purchase	Beds	2,624	25	577	0	111	24	2
3	3	Housekeeping	Beds	2,624	25	0	0	111	0	3
4	4	Laundry	Beds	2,624	25	0	0	111	0	4
5	5	Heat & Other Utilities	Beds	2,624	25	40,565	0	111	1,716	5
6	6	Maintenance	Beds	2,624	25	321,709	65,509	111	13,609	6
7	7	Other	Beds	2,624	25	0	0	111	0	7
8	9	Medical Director	Beds	2,624	25	50,960	0	111	2,156	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	56,488	111	0	9
10	11	Activities	Beds	2,624	25	37,038	36,931	111	1,567	10
11	12	Social Service	Beds	2,624	25	0	0	111	0	11
12	13	Nurse Aide Training	Beds	2,624	25	47,168	47,168	111	1,995	12
13	14	Program Transportation	Beds	2,624	25	0	0	111	0	13
14	15	Other	Beds	2,624	25	0	0	111	0	14
15	17	Administrative	Beds	2,624	25	1,688,288	1,688,288	111	71,418	15
16	18	Directors Fees	Beds	2,624	25	150,218	0	111	6,354	16
17	19	Professional Services	Beds	2,624	25	211,148	0	111	8,932	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	159,872	0	111	6,763	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,706,408	3,356,042	111	156,788	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	1,015,049	0	111	42,938	20
21	23	Inservice Training & Education	Beds	2,624	25	10,511	0	111	445	21
22	24	Travel and Seminar	Beds	2,624	25	243,988	0	111	10,321	22
23	25	Other Admin. Staff Transportatio	Beds	2,624	25	0	0	111	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,624	25	149,629	0	111	6,330	24
25	TOTALS					\$ 7,975,470	\$ 5,392,483		\$ 337,377	25

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

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	\$	111	\$	1
2	30	Depreciation	Beds	2,624	25	259,703	111	10,986	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		111		3
4	32	Interest	Beds	2,624	25	175,477	111	7,423	4
5	33	Real Estate Taxes	Beds	2,624	25		111		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587	111	6,709	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166	111	1,826	7
8	36	Other	Beds	2,624	25		111		8
9	38	Medically Nec Transportation	Beds	2,624	25		111		9
10	39	Ancillary Service Centers	Beds	2,624	25		111		10
11	40	Barber and Beauty Shops	Beds	2,624	25		111		11
12	41	Coffee and Gift Shops	Beds	2,624	25		111		12
13	42	Other	Beds	2,624	25		111		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	\$	\$ 26,944	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			\$	\$ 1,936,334	01/09	variable	\$ 163,859	1								
2	LsSalle National Bank		xx	Mortgage							5,855	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	LsSalle National Bank		xx	Working Capital							15,292	6								
7	LsSalle National Bank		xx									7								
8												8								
9	<b>TOTAL Facility Related</b>						\$	\$ 1,936,334			\$ 185,006	9								
<b>B. Non-Facility Related*</b>																				
10	<b>Interest Income</b>										(2,900)	10								
11	<b>Allocated Corporate</b>										7,423	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 4,523	14								
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 1,936,334			\$ 189,529	15								

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

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

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



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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-Bloomington COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048157

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>21-04-227-012</u>	<u>Nursing Home</u>	\$ <u>74,995.00</u>	\$ <u>74,995.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>74,995.00</u>	\$ <u>74,995.00</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-Bloomington

# 0048157 Report Period Beginning:

01/01/07 Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 25,183 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>116,576</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>116,576</u>	3

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

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	111				\$ 560,548	\$		\$	\$	\$	4
5					221,147						5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9	1978 Improvements			1978	14,607						9
10	1979 Improvements			1979	95,460						10
11	1980 Improvements			1980	75,591						11
12	1981 Improvements			1981	11,544						12
13	1982 Improvements			1982	9,256						13
14	1983 Improvements			1983	13,130						14
15	1984 Improvements			1984	7,215						15
16	1985 Improvements			1985	45,885						16
17	1986 Improvements			1986	13,469						17
18	1988 Improvements			1988	83,109						18
19	1989 Improvements			1989	2,439						19
20	1990 Improvements			1990	30,676						20
21	1991 Improvements			1991	4,207						21
22	1992 Improvements			1992	1,208						22
23	1993 Improvements			1993	97,303						23
24	1994 Improvements			1994	29,638						24
25	1995 Improvements			1995	121,304						25
26	BOILER			1996	17,850						26
27	EXHAUST HOOD			1996	1,075						27
28	CODE ALERT			1996	1,852						28
29	PHONE SYSTEM			1996	2,339						29
30	INTERIOR REMODEL			1996	103,103						30
31											31
32											32
33											33
34	C/O Allocation							10,986	10,986		34
35	Book Depreciation					130,561		130,561		1,458,992	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Heritage Manor-Bloomington

# 0048157

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--paint, wallpaper, remodel facility	1997	\$ 211,945	\$		\$	\$	\$	37
38	Remodel Physical Therapy	1997	43,069						38
39	Disposal Unit--Kitchen	1997	1,439						39
40	Code Alert System	1997	1,997						40
41	Kitchen Remodel	1997	766						41
42									42
43	Code Alert/Nurse Call System	1998	3,654						43
44	Kitchen Remodel	1998	4,166						44
45	Remodel Physical Therapy	1998	1,813						45
46	Addition--Materials	1998	13,431						46
47	Addition--Professional Fees	1998	109,885						47
48									48
49	Addition--Materials	1999	1,155,066						49
50	Addition--Professional Fees	1999	22,035						50
51	Steam Table Hood	1999	3,821						51
52	ALTA Survey	1999	2,434						52
53	Dish Washing Area	1999	4,083						53
54	Sewage Pump	1999	2,492						54
55	Parking Lot Pavement	1999	6,743						55
56									56
57	Dayroom Light Fixtures	2000	6,189						57
58	Door Kickplates	2000	2,991						58
59	Storm windows	2000	4,011						59
60	Addition--Materials	2000	12,770						60
61	Addition--Professional Fees	2000	5,893						61
62	Roof Repair	2000	5,510						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,190,158	\$ 130,561		\$ 141,547	\$ 10,986	\$ 1,458,992	70

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

Facility Name &amp; ID Number Heritage Manor-Bloomington

# 0048157

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 12A, Carried Forward		\$ 3,190,158	\$ 130,561		\$ 141,547	\$ 10,986	\$ 1,458,992	1
2	Paging System	2001	2,456						2
3	Alarm Door/Lock	2001	1,950						3
4	Code Alert	2001	3,965						4
5	Electrical Wiring for A/C Unit	2001	1,805						5
6	Main Water Meter	2001	2,000						6
7	Valves Boiler Unit	2001	1,883						7
8									8
9	Smoke Detectors and Installation	2002	14,551						9
10	Mixing valve	2002	1,862						10
11	Main Corridor Rehab (Wallcovering)	2002	3,885						11
12	Floor Tile	2002	1,280						12
13	Kitchen	2002	957						13
14	Roof Repair	2002	5,283						14
15									15
16	Smoke Detectors and Installation	2003	5,970						16
17	Roof Replacement	2003	111,250						17
18	Sprinklers	2003	31,119						18
19	Parking Lot	2003	3,862						19
20	Ceramic Tile	2003	1,315						20
21	Compressor	2003	3,898						21
22	Wallpaper	2003	857						22
23	Maglock Keypad	2003	2,762						23
24	ANSUL Fire Suppression	2003	1,450						24
25	Fire Escape Remodel	2003	2,003						25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,396,521	\$ 130,561		\$ 141,547	\$ 10,986	\$ 1,458,992	34

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

Facility Name &amp; ID Number Heritage Manor-Bloomington

# 0048157

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 12B, Carried Forward</b>		\$ 3,396,521	\$ 130,561		\$ 141,547	\$ 10,986	\$ 1,458,992	1
2									2
3	Sewage Pump	2004	3,823						3
4	Nurses Station A/C	2004	1,478						4
5	Fire Alarm	2004	2,825						5
6	Sealcoat Parking Lot	2004	1,646						6
7	Storm Windows	2004	645						7
8	Window A/C (8)	2004	6,030						8
9	Ceiling Repairs	2004	4,011						9
10									10
11	Delayed Egress Latches	2005	12,431						11
12	Mixing valve	2005	1,360						12
13	Paint ceiling	2005	596						13
14	A/C	2005	2,153						14
15	Sidewalk	2005	2,100						15
16									16
17	Plumbing	2006	6,791						17
18	A/C -- Thru wall units	2006	6,900						18
19	Exterior Painting	2006	11,650						19
20	Compressor	2006	5,015						20
21	Condensing Unit	2006	4,902						21
22	Insinkerator	2006	2,350						22
23	Water Softener	2006	27,469						23
24	Basement De-watering	2006	3,750						24
25	Paint Kitchen	2006	1,820						25
26	Repair building	2006	1,199						26
27	Landscaping	2006	1,335						27
28	Pump Motor	2006	1,072						28
29	Mixing valve	2006	2,884						29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,512,756	\$ 130,561		\$ 141,547	\$ 10,986	\$ 1,458,992	34

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

Facility Name & ID Number Heritage Manor-Bloomington

# 0048157

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,512,756	\$ 130,561		\$ 141,547	\$ 10,986	\$ 1,458,992	1
2									2
3	Resident Rooms Remodel -- Paint and flooring	2007	13,957						3
4	Sprinkler	2007	1,152						4
5	Compressor	2007	4,006						5
6	Condensor	2007	2,250						6
7	Water Heater	2007	7,359						7
8	Therapy Room Remodel-- Paint & Flooring	2007	2,527						8
9	Window treatments	2007	583						9
10	Cooler	2007	642						10
11	Boiler	2007	4,803						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)		\$ 3,550,035	\$ 130,561		\$ 141,547	\$ 10,986	\$ 1,458,992	34

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

Facility Name & ID Number Heritage Manor-Bloomington # 0048157 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	\$ 1,106,697	\$ 25,486	\$ 25,486	\$		\$ 981,996	71
72	Current Year Purchases	32,285						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,138,982	\$ 25,486	\$ 25,486	\$		\$ 981,996	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)	\$ 4,805,593	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 156,047	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 167,033	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,986	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,440,988	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:		111	07/2006	\$ 243,090	5		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		111		\$ 243,090			7

10. Effective dates of current rental agreement:

Beginning 07/2006

Ending 07/2011

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

Fiscal Year Ending                      Annual Rent

12.	<u>/2008</u>	\$ <u>243,090</u>
13.	<u>/2009</u>	\$ <u>243,090</u>
14.	<u>/2010</u>	\$ <u>243,090</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: \$ 5,462 Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,925		1,925
3	Classroom Wages (a)		8,752		8,752
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 10,677	\$	\$ 10,677
10	SUM OF line 9, col. 1 and 2 (e)	\$	10,677		

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.

## 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	\$		\$ 276,474	\$		\$ 276,474	1
2	Licensed Speech and Language Development Therapist		hrs			32,951			32,951	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			315,628	465		316,093	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				335,782		335,782	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					35,028			35,028	13
14	TOTAL			\$		\$ 660,081	\$ 336,247		\$ 996,328	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-Bloomington# 0048157Report 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	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 10,089	\$	1
2	Cash-Patient Deposits	9,933		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	886,608		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,029		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,328,840)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (407,181)	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	116,576		13
14	Buildings, at Historical Cost	3,492,114		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,107,361		16
17	Accumulated Depreciation (book methods)	(2,440,988)		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):	22,175		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,297,238	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,890,057	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 191,725	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,933		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	255,796		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,346		31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,745		32
33	Accrued Interest Payable	12,797		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>	\$ 552,342	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,936,334		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>	\$ 1,936,334	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,488,676	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (598,619)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,890,057	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (51,734)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (51,734)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(521,885)	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	(25,000)	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>\$ (546,885)</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>\$ (598,619)</b>	24 *

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

Facility Name & ID Number Heritage Manor-Bloomington# 0048157Report 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	\$ 5,171,836	1
2	Discounts and Allowances for all Levels	(2,579,275)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,592,561	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,209,326	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,209,326	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	119	12
13	Barber and Beauty Care	18,381	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,867	16
17	Sale of Drugs	561,595	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 585,962	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,900	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,900	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,390,749	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	945,580	31
32	Health Care	3,174,159	32
33	General Administration	1,360,181	33
<b>B. Capital Expense</b>			
34	Ownership	420,028	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	12,686	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>	\$ 5,912,634	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(521,885)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (521,885)	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-Bloomington

# 0048157

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	1,976	2,072	\$ 56,283	\$ 27.16	1
2	Assistant Director of Nursing	1,778	2,080	44,897	21.59	2
3	Registered Nurses	4,282	4,861	103,264	21.24	3
4	Licensed Practical Nurses	22,551	24,962	523,711	20.98	4
5	CNAs & Orderlies	63,482	68,018	811,649	11.93	5
6	CNA Trainees	1,000	1,000	8,752	8.75	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,918	4,191	74,890	17.87	8
9	Activity Director					9
10	Activity Assistants	6,263	6,885	64,743	9.40	10
11	Social Service Workers	1,998	2,194	32,114	14.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,620	21,309	238,514	11.19	15
16	Dishwashers					16
17	Maintenance Workers	8,436	9,149	109,316	11.95	17
18	Housekeepers	8,581	9,108	70,338	7.72	18
19	Laundry	6,596	7,100	67,786	9.55	19
20	Administrator	1,900	2,080	61,055	29.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,438	11,461	166,881	14.56	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)	162,819	176,470	\$ 2,434,193 *	\$ 13.79	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		12,000		36
37	Medical Records Consultant		1,500		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,330		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		3,954		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 20,784		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	796	\$ 31,837		50
51	Licensed Practical Nurses	4,076	142,669		51
52	Certified Nurse Assistants/Aides	2,891	72,264		52
53	TOTAL (lines 50 - 52)	7,763	\$ 246,770		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? \_\_\_\_\_
- (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 Bloomington 38349 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 60,773  
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. \$ 823
- (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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