

		FOR BHF USE				

LL1

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: 0048108

Facility Name: Heritage Manor-Mendota

Address: 1201 First Avenue Mendota 61342
 Number City Zip Code

County: LaSalle

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

HFS ID Number: 203904038001

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
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 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.

Officer or Administrator of Provider	(Signed) _____	<u>04/15/08</u>
	(Type or Print Name) <u>Craig Ater</u>	(Date)
Paid Preparer	(Title) <u>Sr. VP & CFO</u>	
	(Signed) _____	(Date)
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) <u>()</u>	Fax # <u>()</u>

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

Facility Name & ID Number Heritage Manor-Mendota# 0048108 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>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,663</u>	<u>9,003</u>	<u>3,460</u>	<u>27,126</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,663</u>	<u>9,003</u>	<u>3,460</u>	<u>27,126</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.07%

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 & 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 3,460Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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
	A. General Services										
1	Dietary	184,511	20,028		204,539		204,539	5,370	209,909		1
2	Food Purchase		137,717		137,717		137,717	22	137,739		2
3	Housekeeping	71,511	21,597		93,108		93,108		93,108		3
4	Laundry	58,535	16,319		74,854		74,854		74,854		4
5	Heat and Other Utilities			86,464	86,464		86,464	1,530	87,994		5
6	Maintenance	51,120	29,402	39,853	120,375		120,375	12,138	132,513		6
7	Other (specify):*										7
8	TOTAL General Services	365,677	225,063	126,317	717,057		717,057	19,060	736,117		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400	1,923	10,323		9
10	Nursing and Medical Records	1,188,583	95,175	177,609	1,461,367		1,461,367		1,461,367		10
10a	Therapy		214,583	374,998	589,581	(278,027)	311,554	153,327	464,881		10a
11	Activities	62,529	3,634		66,163		66,163	1,397	67,560		11
12	Social Services	28,419		1,467	29,886		29,886		29,886		12
13	CNA Training							1,780	1,780		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,279,531	313,392	562,474	2,155,397	(278,027)	1,877,370	158,427	2,035,797		16
	C. General Administration										
17	Administrative	69,130			69,130		69,130	63,697	132,827		17
18	Directors Fees							5,668	5,668		18
19	Professional Services			192,281	192,281		192,281	(182,815)	9,466		19
20	Dues, Fees, Subscriptions & Promotions			92,692	92,692	(54,203)	38,489	(18,439)	20,050		20
21	Clerical & General Office Expenses	126,712	15,758	15,958	158,428		158,428	139,838	298,266		21
22	Employee Benefits & Payroll Taxes			482,082	482,082		482,082	38,296	520,378		22
23	Inservice Training & Education			1,599	1,599		1,599	397	1,996		23
24	Travel and Seminar			3,284	3,284		3,284	(1,285)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			63,646	63,646		63,646	5,645	69,291		26
27	Other (specify):*			3,000	3,000		3,000	(3,000)			27
28	TOTAL General Administration	195,842	15,758	854,542	1,066,142	(54,203)	1,011,939	48,002	1,059,941		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,841,050	554,213	1,543,333	3,938,596	(332,230)	3,606,366	225,489	3,831,855		29

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

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

Facility Name & ID Number Heritage Manor-Mendota #0048108 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	
	D. Ownership											
30	Depreciation			138,078	138,078		138,078	9,798	147,876			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			171,435	171,435		171,435	1,870	173,305			32
33	Real Estate Taxes			73,732	73,732		73,732		73,732			33
34	Rent-Facility & Grounds							5,983	5,983			34
35	Rent-Equipment & Vehicles			(995)	(995)		(995)	1,629	634			35
36	Other (specify):*											36
37	TOTAL Ownership			382,250	382,250		382,250	19,280	401,530			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					278,027	278,027		278,027			39
40	Barber and Beauty Shops		250	8,043	8,293		8,293		8,293			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					54,203	54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		250	8,043	8,293	332,230	340,523		340,523			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,841,050	554,463	1,933,626	4,329,139		4,329,139	244,769	4,573,908			45

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

Facility Name & ID Number Heritage Manor-Mendota

0048108

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	(4,751)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(10,490)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(447)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,000)	27		24
25	Fund Raising, Advertising and Promotional	(23,471)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (43,159)		\$	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)	287,928		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 287,928		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 244,769		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

Heritage Manor-Mendota

ID# 0048108

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		(1,000)	20
18			18
19			24
20		0	27
21			21
22		(447)	19
23			23
24		(3,000)	27
25		(23,471)	20
26			26
27			27
28			28
29		0	33
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(27,918)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Mendota

0048108

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)	
	A. General Services													
1	Dietary	0	0	5,370	0	0	0	0	0	0	0	0	5,370	1
2	Food Purchase	0	0	22	0	0	0	0	0	0	0	0	22	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	1,530	0	0	0	0	0	0	0	0	1,530	5
6	Maintenance	0	0	12,138	0	0	0	0	0	0	0	0	12,138	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	19,060	0	0	0	0	0	0	0	0	19,060	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,923	0	0	0	0	0	0	0	0	1,923	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	153,327	0	0	0	0	0	0	0	0	0	153,327	10a
11	Activities	0	0	1,397	0	0	0	0	0	0	0	0	1,397	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,780	0	0	0	0	0	0	0	0	1,780	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	153,327	5,100	0	0	0	0	0	0	0	0	158,427	16
	C. General Administration													
17	Administrative	0	0	63,697	0	0	0	0	0	0	0	0	63,697	17
18	Directors Fees	0	0	5,668	0	0	0	0	0	0	0	0	5,668	18
19	Professional Services	(447)	(190,334)	7,966	0	0	0	0	0	0	0	0	(182,815)	19
20	Fees, Subscriptions & Promotions	(24,471)	0	6,032	0	0	0	0	0	0	0	0	(18,439)	20
21	Clerical & General Office Expenses	0	0	139,838	0	0	0	0	0	0	0	0	139,838	21
22	Employee Benefits & Payroll Taxes	0	0	38,296	0	0	0	0	0	0	0	0	38,296	22
23	Inservice Training & Education	0	0	397	0	0	0	0	0	0	0	0	397	23
24	Travel and Seminar	(10,490)	0	9,205	0	0	0	0	0	0	0	0	(1,285)	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	5,645	0	0	0	0	0	0	0	0	5,645	26
27	Other (specify):*	(3,000)	0	0	0	0	0	0	0	0	0	0	(3,000)	27
28	TOTAL General Administration	(38,408)	(190,334)	276,744	0	0	0	0	0	0	0	0	48,002	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(38,408)	(37,007)	300,904	0	0	0	0	0	0	0	0	225,489	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Mendota

0048108

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	9,798	0	0	0	0	0	0	0	9,798	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,751)	0	0	6,621	0	0	0	0	0	0	0	1,870	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	5,983	0	0	0	0	0	0	0	5,983	34
35	Rent-Equipment & Vehicles	0	0	0	1,629	0	0	0	0	0	0	0	1,629	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,751)	0	0	24,031	0	19,280	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(43,159)	(37,007)	300,904	24,031	0	244,769	45						

Facility Name & ID Number Heritage Manor-Mendota

0048108

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:
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)
1	V		\$			\$	\$
2	V	10a Adjustment for Related Organization					
3	V						
4	V	19 Adjustment for Related Organization	190,334	Heritage Enterprises, Inc.			(190,334)
5	V						
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		153,327	153,327
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 190,334			\$ 153,327	\$ * (37,007)

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

Facility Name & ID Number Heritage Manor-Mendota# 0048108Report 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%	\$	5,370	15
16	V	2 Food Purchase					22	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,530	19
20	V	6 Maintenance					12,138	20
21	V	7 Other					0	21
22	V	9 Medical Director					1,923	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					1,397	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,780	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					63,697	29
30	V	18 Directors Fees					5,668	30
31	V	19 Professional Services					7,966	31
32	V	20 Fees, Subscription, Promotions					6,032	32
33	V	21 Clerical & General Office Expenses					139,838	33
34	V	22 Employee Benefits & Payroll Taxes					38,296	34
35	V	23 Inservice Training & Education					397	35
36	V	24 Travel and Seminar					9,205	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					5,645	38
39	Total		\$			\$	0	\$ * 300,904 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27 Other	\$		100.00%	\$	0	15
16	V	30 Depreciation					9,798	16
17	V	31 Amortization of Pre-Op & Org						17
18	V	32 Interest					6,621	18
19	V	33 Real Estate Taxes					0	19
20	V	34 Rent-Facility & Grounds					5,983	20
21	V	35 Rent-Equipment & Vehicles					1,629	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	\$ * 24,031 39

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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					\$ 5,668	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	\$ 5,668		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Heritage Manor-Mendota

0048108

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	99	\$ 5,370	1
2	2	Food Purchase	Beds 2,624	25	577	0	99	22	2
3	3	Housekeeping	Beds 2,624	25	0	0	99	0	3
4	4	Laundry	Beds 2,624	25	0	0	99	0	4
5	5	Heat & Other Utilities	Beds 2,624	25	40,565	0	99	1,530	5
6	6	Maintenance	Beds 2,624	25	321,709	65,509	99	12,138	6
7	7	Other	Beds 2,624	25	0	0	99	0	7
8	9	Medical Director	Beds 2,624	25	50,960	0	99	1,923	8
9	10	Nursing & Medical Records	Beds 2,624	25	0	56,488	99	0	9
10	11	Activities	Beds 2,624	25	37,038	36,931	99	1,397	10
11	12	Social Service	Beds 2,624	25	0	0	99	0	11
12	13	Nurse Aide Training	Beds 2,624	25	47,168	47,168	99	1,780	12
13	14	Program Transportation	Beds 2,624	25	0	0	99	0	13
14	15	Other	Beds 2,624	25	0	0	99	0	14
15	17	Administrative	Beds 2,624	25	1,688,288	1,688,288	99	63,697	15
16	18	Directors Fees	Beds 2,624	25	150,218	0	99	5,668	16
17	19	Professional Services	Beds 2,624	25	211,148	0	99	7,966	17
18	20	Fees, Subscription, Promotions	Beds 2,624	25	159,872	0	99	6,032	18
19	21	Clerical & General Office Expense	Beds 2,624	25	3,706,408	3,356,042	99	139,838	19
20	22	Employee Benefits & Payroll Tax	Beds 2,624	25	1,015,049	0	99	38,296	20
21	23	Inservice Training & Education	Beds 2,624	25	10,511	0	99	397	21
22	24	Travel and Seminar	Beds 2,624	25	243,988	0	99	9,205	22
23	25	Other Admin. Staff Transportatio	Beds 2,624	25	0	0	99	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds 2,624	25	149,629	0	99	5,645	24
25	TOTALS				\$ 7,975,470	\$ 5,392,483		\$ 300,904	25

Facility Name & ID Number Heritage Manor-Mendota

0048108

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	\$	99	\$	1
2	30	Depreciation	Beds	2,624	25	259,703	99	9,798	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		99		3
4	32	Interest	Beds	2,624	25	175,477	99	6,621	4
5	33	Real Estate Taxes	Beds	2,624	25		99		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587	99	5,983	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166	99	1,629	7
8	36	Other	Beds	2,624	25		99		8
9	38	Medically Nec Transportation	Beds	2,624	25		99		9
10	39	Ancillary Service Centers	Beds	2,624	25		99		10
11	40	Barber and Beauty Shops	Beds	2,624	25		99		11
12	41	Coffee and Gift Shops	Beds	2,624	25		99		12
13	42	Other	Beds	2,624	25		99		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 636,933	\$		\$ 24,031	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LsSalle National Bank		xx	Mortgage			\$	1,825,361		\$	152,013	1								
2	LsSalle National Bank		xx	Mortgage							5,767	2								
3												3								
4												4								
5												5								
Working Capital																				
6	LsSalle National Bank		xx	Working Capital							13,655	6								
7	LsSalle National Bank		xx									7								
8												8								
9	TOTAL Facility Related						\$	1,825,361		\$	171,435	9								
B. Non-Facility Related*																				
10	Interest Income										(4,751)	10								
11	Allocated Corporate										6,621	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$			\$	1,870	14								
15	TOTALS (line 9+line14)						\$	1,825,361		\$	173,305	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 30,791	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.)		\$ 58,964	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 28,173	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 45,559	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 73,732	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	25,412	8
	2003	24,907	9
	2004	26,183	10
	2005	32,066	11
	2006	73,732	12
	FOR BHF USE ONLY		
	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-Mendota COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048108

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>01-34-100-020</u>	<u>nursing home</u>	\$ <u>43,389.00</u>	\$ <u>43,389.00</u>
2. <u>01-34-100-020</u>	<u></u>	\$ <u>15,575.00</u>	\$ <u>15,575.00</u>
3. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>58,964.00</u>	\$ <u>58,964.00</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-Mendota

0048108 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,555 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>26,150</u>	1
2					2
3	TOTALS			\$ <u>26,150</u>	3

Facility Name & ID Number Heritage Manor-Mendota

0048108

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	99				\$ 697,500	\$		\$	\$	\$	4
5					408,657						5
6											6
7											7
8											8
Improvement Type**											
9	1980 Improvements			1980	8,150						9
10	1981 Improvements			1981	20,492						10
11	1982 Improvements			1982	9,185						11
12	1983 Improvements			1983	5,682						12
13	1984 Improvements			1984	11,488						13
14	1985 Improvements			1985	7,710						14
15	1986 Improvements			1986	2,255						15
16	1987 Improvements			1987	9,037						16
17	1988 Improvements			1988	21,297						17
18	1989 Improvements			1989	4,653						18
19	1990 Improvements			1990	36,595						19
20	1991 Improvements			1991							20
21	1992 Improvements			1992	10,646						21
22	1993 Improvements			1993	62,261						22
23	1994 Improvements			1994	10,869						23
24	1995 Improvements			1995	18,523						24
25	Exterior Door			1996	2,563						25
26	Shower Tile			1996	806						26
27	Kitchen Heat/Cool Unit			1996	14,062						27
28	Resident Room Painting			1996	2,067						28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							9,798	9,798		34
35	Book Depreciation					100,655		100,655		970,684	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-Mendota

0048108

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	Garbage Disposal	1997	\$ 2,030	\$		\$	\$	\$	37
38	Generator	1997	39,380						38
39	Parking Lot Asphalt	1997	2,210						39
40	Shower	1997	701						40
41									41
42	Kitchen Drain	1998	3,245						42
43	Walk in Cooler Repair	1998	2,215						43
44	A/C Unit	1998	1,615						44
45	Landscaping	1998	4,696						45
46									46
47	Door Alarm System	1999	11,750						47
48	Air Conditioning Condensing Unit	1999	1,027						48
49	Water Softener	1999	4,493						49
50									50
51	Air conditioner (3)	2000	2,221						51
52	Sprinklers	2000	1,864						52
53	Resident Room Doors (45)	2000	1,724						53
54	Facility Remodel -- Materials (see attached detail)	2000	410,365						54
55	Facility Remodel -- Labor (see attached detail)	2000	4,030						55
56	Facility Remodel -- Professional Fees (see attached detail)	2000	23,932						56
57	Facility Remodel -- Interior Design (see attached detail)	2000	36,998						57
58	Water Softener	2000	4,713						58
59									59
60	Parking Spaces	2001	1,452						60
61	Water Heater	2001	2,847						61
62									62
63	Water Heater	2002	3,816						63
64	Wood door	2002	677						64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,932,499	\$ 100,655		\$ 110,453	\$ 9,798	\$ 970,684	70

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

Facility Name & ID Number Heritage Manor-Mendota

0048108

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		\$ 1,932,499	\$ 100,655		\$ 110,453	\$ 9,798	\$ 970,684	1
2									2
3	Furnace	2003	2,491						3
4	A/C Unit	2003	3,083						4
5	Condensing Unit	2003	1,353						5
6									6
7	Heat/Cool Unit	2004	2,498						7
8	Disposal	2004	989						8
9	Garage Repairs	2004	4,866						9
10	Compressor	2004	1,805						10
11	Emergency Outlets	2004	1,565						11
12	Furnace	2004	6,280						12
13									13
14	Exterior Door	2005	3,161						14
15	Holding Tank	2005	3,897						15
16	Smoke Detector	2005	1,919						16
17	A/C Unit	2005	4,248						17
18	Parking Lot	2005	68,313						18
19	Dumpster Pad	2005	1,547						19
20	Sidewalks	2005	7,850						20
21									21
22	Floor -- entry way	2006	19,178						22
23	Shower rehab	2006	6,246						23
24	Phone system	2006	1,836						24
25	A/C Unit	2006	2,201						25
26	Compressor	2006	1,642						26
27	Remodel TLC unit -- paint, wallpaper	2006	6,126						27
28	Parking Lot	2006	3,633						28
29	Roof	2006	148,938						29
30	Valance	2006	581						30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,238,745	\$ 100,655		\$ 110,453	\$ 9,798	\$ 970,684	34

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

Facility Name & ID Number Heritage Manor-Mendota

0048108

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		\$ 2,238,745	\$ 100,655		\$ 110,453	\$ 9,798	\$ 970,684	1
2									2
3	Metal Roof	2007	49,988						3
4	Door Alarm	2007	2,986						4
5	HVAC	2007	3,370						5
6	Sprinkler system	2007	101,380						6
7	Wander Alarm	2007	8,092						7
8	fire Alarm	2007	42,223						8
9	Water Heater	2007	3,820						9
10	Grab Bars	2007	4,193						10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,454,797	\$ 100,655		\$ 110,453	\$ 9,798	\$ 970,684	34

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

Facility Name & ID Number Heritage Manor-Mendota # 0048108 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	\$ 813,892	\$ 37,423	\$ 37,423	\$		\$ 636,289	71
72	Current Year Purchases	20,026						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 833,918	\$ 37,423	\$ 37,423	\$		\$ 636,289	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,314,865	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 138,078	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 147,876	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,798	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,606,973	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:		99	07/2006	\$ 216,810	5		3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$ 216,810			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>216,810</u>
13.	<u>/2009</u>	\$ <u>216,810</u>
14.	<u>/2010</u>	\$ <u>216,810</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: \$ 634 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	\$		\$ 148,539	\$		\$ 148,539	1
2	Licensed Speech and Language Development Therapist		hrs			4,482			4,482	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			157,996	537		158,533	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				214,046		214,046	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					63,981			63,981	13
14	TOTAL			\$		\$ 374,998	\$ 214,583		\$ 589,581	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Manor-Mendota # 0048108 Report 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 23,521	\$	1
2	Cash-Patient Deposits	8,449		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	456,920		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,206		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	123,841		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 644,937	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	26,150		13
14	Buildings, at Historical Cost	2,259,831		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	793,994		16
17	Accumulated Depreciation (book methods)	(1,606,973)		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):	21,823		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,494,825	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,139,762	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 121,546	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,449		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	162,313		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,553		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,559		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 358,420	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,825,361		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,825,361	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,183,781	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (44,019)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,139,762	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,836,728	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,836,728	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	19,253	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,900,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,880,747)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (44,019)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Mendota

0048108

Report Period Beginning: 01/01/07

Ending: 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,361,184	1
2	Discounts and Allowances for all Levels	(1,681,159)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,680,025	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,289,548	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,289,548	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	635	12
13	Barber and Beauty Care	10,757	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	406	16
17	Sale of Drugs	362,270	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 374,068	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,751	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,751	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,348,392	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	717,057	31
32	Health Care	2,155,397	32
33	General Administration	1,066,142	33
B. Capital Expense			
34	Ownership	382,250	34
C. Ancillary Expense			
35	Special Cost Centers	8,293	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,329,139	40
41	Income before Income Taxes (line 30 minus line 40)**	19,253	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 19,253	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor-Mendota

0048108

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	1,832	2,080	\$ 51,690	\$ 24.85	1
2	Assistant Director of Nursing	1,896	2,080	45,691	21.97	2
3	Registered Nurses	8,657	9,924	254,535	25.65	3
4	Licensed Practical Nurses	13,119	14,183	299,874	21.14	4
5	CNAs & Orderlies	42,102	44,552	536,793	12.05	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	5,247	5,928	62,529	10.55	10
11	Social Service Workers	1,799	2,071	28,419	13.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,312	19,741	184,511	9.35	15
16	Dishwashers					16
17	Maintenance Workers	3,739	4,024	51,120	12.70	17
18	Housekeepers	6,550	7,229	71,511	9.89	18
19	Laundry	6,639	7,185	58,535	8.15	19
20	Administrator	1,900	2,080	69,130	33.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,328	8,297	126,712	15.27	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)	119,120	129,374	\$ 1,841,050 *	\$ 14.23	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		8,400		36
37	Medical Records Consultant		447		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,970		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,467		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,284		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	263	\$ 10,521		50
51	Licensed Practical Nurses	1,527	53,462		51
52	Certified Nurse Assistants/Aides	4,288	107,209		52
53	TOTAL (lines 50 - 52)	6,079	\$ 171,192		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 Mendota 38364 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 14,632
- (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.

Line	Account	Debit	Credit	Balance	Account	Debit	Credit	Balance
1000	1000				1000			
1001	1001				1001			
1002	1002				1002			
1003	1003				1003			
1004	1004				1004			
1005	1005				1005			
1006	1006				1006			
1007	1007				1007			
1008	1008				1008			
1009	1009				1009			
1010	1010				1010			
1011	1011				1011			
1012	1012				1012			
1013	1013				1013			
1014	1014				1014			
1015	1015				1015			
1016	1016				1016			
1017	1017				1017			
1018	1018				1018			
1019	1019				1019			
1020	1020				1020			
1021	1021				1021			
1022	1022				1022			
1023	1023				1023			
1024	1024				1024			
1025	1025				1025			
1026	1026				1026			
1027	1027				1027			
1028	1028				1028			
1029	1029				1029			
1030	1030				1030			
1031	1031				1031			
1032	1032				1032			
1033	1033				1033			
1034	1034				1034			
1035	1035				1035			
1036	1036				1036			
1037	1037				1037			
1038	1038				1038			
1039	1039				1039			
1040	1040				1040			
1041	1041				1041			
1042	1042				1042			
1043	1043				1043			
1044	1044				1044			
1045	1045				1045			
1046	1046				1046			
1047	1047				1047			
1048	1048				1048			
1049	1049				1049			
1050	1050				1050			
1051	1051				1051			
1052	1052				1052			
1053	1053				1053			
1054	1054				1054			
1055	1055				1055			
1056	1056				1056			
1057	1057				1057			
1058	1058				1058			
1059	1059				1059			
1060	1060				1060			
1061	1061				1061			
1062	1062				1062			
1063	1063				1063			
1064	1064				1064			
1065	1065				1065			
1066	1066				1066			
1067	1067				1067			
1068	1068				1068			
1069	1069				1069			
1070	1070				1070			
1071	1071				1071			
1072	1072				1072			
1073	1073				1073			
1074	1074				1074			
1075	1075				1075			
1076	1076				1076			
1077	1077				1077			
1078	1078				1078			
1079	1079				1079			
1080	1080				1080			
1081	1081				1081			
1082	1082				1082			
1083	1083				1083			
1084	1084				1084			
1085	1085				1085			
1086	1086				1086			
1087	1087				1087			
1088	1088				1088			
1089	1089				1089			
1090	1090				1090			
1091	1091				1091			
1092	1092				1092			
1093	1093				1093			
1094	1094				1094			
1095	1095				1095			
1096	1096				1096			
1097	1097				1097			
1098	1098				1098			
1099	1099				1099			
1100	1100				1100			
1101	1101				1101			
1102	1102				1102			
1103	1103				1103			
1104	1104				1104			
1105	1105				1105			
1106	1106				1106			
1107	1107				1107			
1108	1108				1108			
1109	1109				1109			
1110	1110				1110			
1111	1111				1111			
1112	1112				1112			
1113	1113				1113			
1114	1114				1114			
1115	1115				1115			
1116	1116				1116			
1117	1117				1117			
1118	1118				1118			
1119	1119				1119			
1120	1120				1120			
1121	1121				1121			
1122	1122				1122			
1123	1123				1123			
1124	1124				1124			
1125	1125				1125			
1126	1126				1126			
1127	1127				1127			
1128	1128				1128			
1129	1129				1129			
1130	1130				1130			
1131	1131				1131			
1132	1132				1132			
1133	1133				1133			
1134	1134				1134			
1135	1135				1135			
1136	1136				1136			
1137	1137				1137			
1138	1138				1138			
1139	1139				1139			
1140	1140				1140			
1141	1141				1141			
1142	1142				1142			
1143	1143				1143			
1144	1144				1144			
1145	1145				1145			
1146	1146				1146			
1147	1147				1147			
1148	1148				1148			
1149	1149				1149			
1150	1150				1150			
1151	1151				1151			
1152	1152				1152			
1153	1153				1153			
1154	1154				1154			
1155	1155				1155			
1156	1156				1156			
1157	1157				1157			
1158	1158				1158			
1159	1159				1159			
1160	1160				1160			
1161	1161				1161			
1162	1162				1162			
1163	1163				1163			
1164	1164				1164			
1165	1165				1165			
1166	1166				1166			
1167	1167				1167			
1168	1168				1168			
1169	1169				1169			
1170	1170				1170			
1171	1171				1171			
1172	1172				1172			
1173	1173				1173			
1174	1174				1174			
1175	1175				1175			
1176	1176				1176			
1177	1177				1177			
1178	1178				1178			
1179	1179				1179			
1180	1180				1180			
1181	1181				1181			
1182	1182				1182			

-

-