



Facility Name & ID Number Heritage Manor-Minonk# 0048058 Report Period Beginning: 01/01/08 Ending: 12/31/08

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>49</u>	Skilled (SNF)	<u>49</u>	<u>17,885</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>23</u>	Sheltered Care (SC)	<u>23</u>	<u>8,395</u>	5
6		ICF/DD 16 or Less			6
7	<u>72</u>	TOTALS	<u>72</u>	<u>26,280</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>8,263</u>	<u>5,436</u>	<u>2,364</u>	<u>16,063</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>4,603</u>		<u>4,603</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,263</u>	<u>10,039</u>	<u>2,364</u>	<u>20,666</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.64%

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)

noneF. Does the facility maintain a daily midnight census? yes

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

YES  NO 

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

YES  NO 

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

Date started 07/2006

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

YES  Date 07/2006 NO 

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 2,364Medicare 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-Minonk # 0048058 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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	196,542	11,538		208,080		208,080	3,963	212,043		1
2	Food Purchase		113,529		113,529		113,529		113,529		2
3	Housekeeping	77,570	10,763		88,333		88,333	15	88,348		3
4	Laundry	51,163	7,767		58,930		58,930		58,930		4
5	Heat and Other Utilities			97,668	97,668		97,668	1,395	99,063		5
6	Maintenance	54,792	44,340	32,454	131,586		131,586	9,925	141,511		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>380,067</b>	<b>187,937</b>	<b>130,122</b>	<b>698,126</b>		<b>698,126</b>	<b>15,298</b>	<b>713,424</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			1,025	1,025		1,025	1,618	2,643		9
10	Nursing and Medical Records	969,764	64,403	18,130	1,052,297		1,052,297		1,052,297		10
10a	Therapy		204,496	224,820	429,316	(212,015)	217,301	60,446	277,747		10a
11	Activities	55,695	3,660		59,355		59,355	1,042	60,397		11
12	Social Services	33,710		2,155	35,865		35,865		35,865		12
13	CNA Training	2,063	110		2,173		2,173	824	2,997		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,061,232</b>	<b>272,669</b>	<b>246,130</b>	<b>1,580,031</b>	<b>(212,015)</b>	<b>1,368,016</b>	<b>63,930</b>	<b>1,431,946</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	74,118			74,118		74,118	50,184	124,302		17
18	Directors Fees							5,345	5,345		18
19	Professional Services			149,823	149,823		149,823	(144,377)	5,446		19
20	Dues, Fees, Subscriptions & Promotions			44,633	44,633	(26,828)	17,805	(918)	16,887		20
21	Clerical & General Office Expenses	93,486	19,261	6,686	119,433		119,433	112,602	232,035		21
22	Employee Benefits & Payroll Taxes			315,972	315,972		315,972	23,012	338,984		22
23	Inservice Training & Education			2,170	2,170		2,170	(171)	1,999		23
24	Travel and Seminar			9,682	9,682		9,682	(7,683)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			35,349	35,349		35,349	8,001	43,350		26
27	Other (specify):*			(12,950)	(12,950)		(12,950)	12,950			27
28	<b>TOTAL General Administration</b>	<b>167,604</b>	<b>19,261</b>	<b>551,365</b>	<b>738,230</b>	<b>(26,828)</b>	<b>711,402</b>	<b>58,945</b>	<b>770,347</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,608,903</b>	<b>479,867</b>	<b>927,617</b>	<b>3,016,387</b>	<b>(238,843)</b>	<b>2,777,544</b>	<b>138,173</b>	<b>2,915,717</b>		<b>29</b>

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

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

Facility Name & ID Number Heritage Manor-Minonk #0048058 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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							79,612	79,612			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,336	7,336		7,336	73,280	80,616			32
33	Real Estate Taxes							34,664	34,664			33
34	Rent-Facility & Grounds			315,360	315,360		315,360	(307,551)	7,809			34
35	Rent-Equipment & Vehicles			1,553	1,553		1,553	1,332	2,885			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			324,249	324,249		324,249	(118,663)	205,586			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					212,015	212,015		212,015			39
40	Barber and Beauty Shops			6	6		6		6			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					26,828	26,828		26,828			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			6	6	238,843	238,849		238,849			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,608,903	479,867	1,251,872	3,340,642		3,340,642	19,510	3,360,152			45

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

Facility Name & ID Number Heritage Manor-Minonk

# 0048058

Report Period Beginning: 01/01/08

Ending: 12/31/08

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(1,864)	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)	(662)	24		16
17	Non-Care Related Fees	(346)	20		17
18	Fines and Penalties				18
19	Entertainment	(14,888)	24		19
20	Contributions	(50)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,853)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	13,000	27		24
25	Fund Raising, Advertising and Promotional	(5,417)	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>	\$ (13,080)		\$	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)	32,590		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 32,590		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 19,510		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Minonk

ID# 0048058

Report Period Beginning: 01/01/08

Ending: 12/31/08

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		(662)	23
17		(346)	20
18			18
19			24
20		(50)	27
21			21
22		(2,853)	19
23			23
24		13,000	27
25		(5,417)	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>	3,672	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Minonk

# 0048058

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	3,963	0	0	0	0	0	0	0	0	3,963	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	15	0	0	0	0	0	0	0	0	15	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,395	0	0	0	0	0	0	0	0	1,395	5
6	Maintenance	0	0	9,925	0	0	0	0	0	0	0	0	9,925	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	15,298	0	0	0	0	0	0	0	0	15,298	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	1,618	0	0	0	0	0	0	0	0	1,618	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	60,446	0	0	0	0	0	0	0	0	0	60,446	10a
11	Activities	0	0	1,042	0	0	0	0	0	0	0	0	1,042	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	824	0	0	0	0	0	0	0	0	824	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	60,446	3,484	0	0	0	0	0	0	0	0	63,930	16
	<b>C. General Administration</b>													
17	Administrative	0	0	50,184	0	0	0	0	0	0	0	0	50,184	17
18	Directors Fees	0	0	5,345	0	0	0	0	0	0	0	0	5,345	18
19	Professional Services	(2,853)	(146,970)	5,446	0	0	0	0	0	0	0	0	(144,377)	19
20	Fees, Subscriptions & Promotions	(5,763)	0	4,845	0	0	0	0	0	0	0	0	(918)	20
21	Clerical & General Office Expenses	0	0	112,602	0	0	0	0	0	0	0	0	112,602	21
22	Employee Benefits & Payroll Taxes	0	0	23,012	0	0	0	0	0	0	0	0	23,012	22
23	Inservice Training & Education	(662)	0	491	0	0	0	0	0	0	0	0	(171)	23
24	Travel and Seminar	(14,888)	0	7,205	0	0	0	0	0	0	0	0	(7,683)	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	8,001	0	0	0	0	0	0	0	0	8,001	26
27	Other (specify):*	12,950	0	0	0	0	0	0	0	0	0	0	12,950	27
28	<b>TOTAL General Administration</b>	(11,216)	(146,970)	217,131	0	0	0	0	0	0	0	0	58,945	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(11,216)	(86,524)	235,913	0	0	0	0	0	0	0	0	138,173	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Minonk

# 0048058

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	71,919	0	7,693	0	0	0	0	0	0	0	79,612	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,864)	70,514	0	4,630	0	0	0	0	0	0	0	73,280	32
33	Real Estate Taxes	0	34,664	0	0	0	0	0	0	0	0	0	34,664	33
34	Rent-Facility & Grounds	0	(315,360)	0	7,809	0	0	0	0	0	0	0	(307,551)	34
35	Rent-Equipment & Vehicles	0	0	0	1,332	0	0	0	0	0	0	0	1,332	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,864)</b>	<b>(138,263)</b>	<b>0</b>	<b>21,464</b>	<b>0</b>	<b>(118,663)</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>(13,080)</b>	<b>(224,787)</b>	<b>235,913</b>	<b>21,464</b>	<b>0</b>	<b>19,510</b>	<b>45</b>						

Facility Name & ID Number Heritage Manor-Minonk

# 0048058

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	GreenTree Pharmacy		60,446	60,446
3	V						
4	V	19	Adjustment for Related Organization	Heritage Operations Group, LLC	0.00%		(146,970)
5	V						
6	V	34	Adjustment for Related Organization	Heritage Manor Real Estate, LLC	0.00%		(315,360)
7	V	33	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		34,664	34,664
8	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		64,502	64,502
9	V	30	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		71,919	71,919
10	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		6,012	6,012
11	V						
12	V						
13	V						
14	Total		\$ 462,330			\$ 237,543	\$ * (224,787)

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

Facility Name & ID Number Heritage Manor-Minonk# 0048058Report Period Beginning: 01/01/08Ending: 12/31/08**VII. RELATED PARTIES (continued)**

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$ 3,963	\$ 3,963	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				15	15	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,395	1,395	19
20	V	6 Maintenance				9,925	9,925	20
21	V	7 Other				0		21
22	V	9 Medical Director				1,618	1,618	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,042	1,042	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				824	824	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				50,184	50,184	29
30	V	18 Directors Fees				5,345	5,345	30
31	V	19 Professional Services				5,446	5,446	31
32	V	20 Fees, Subscription, Promotions				4,845	4,845	32
33	V	21 Clerical & General Office Expenses				112,602	112,602	33
34	V	22 Employee Benefits & Payroll Taxes				23,012	23,012	34
35	V	23 Inservice Training & Education				491	491	35
36	V	24 Travel and Seminar				7,205	7,205	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				8,001	8,001	38
39	Total		\$			\$ 235,913	\$ * 235,913	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	\$		0.00%	\$ 0			15
16	V	30 Depreciation				7,693	7,693		16
17	V	31 Amortization of Pre-Op & Org				0			17
18	V	32 Interest				4,630	4,630		18
19	V	33 Real Estate Taxes				0			19
20	V	34 Rent-Facility & Grounds				7,809	7,809		20
21	V	35 Rent-Equipment & Vehicles				1,332	1,332		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		\$			\$ 21,464	\$ *	21,464	39

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

Facility Name & ID Number Heritage Manor-Minonk # 0048058 Report Period Beginning: 01/01/08 Ending: 12/31/08

## 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					\$ 5,345	18/7	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	\$ 5,345		13

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

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

Facility Name & ID Number Heritage Manor-Minonk

# 0048058

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	2,634	25	\$ 144,981	\$ 144,706	72	\$ 3,963	1
2	2	Food Purchase	Beds	2,634	25	0	0	72	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	72	15	3
4	4	Laundry	Beds	2,634	25	0	0	72	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	72	1,395	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	72	9,925	6
7	7	Other	Beds	2,634	25	0	0	72	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	72	1,618	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	72	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	72	1,042	10
11	12	Social Service	Beds	2,634	25	0	0	72	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	72	824	12
13	14	Program Transportation	Beds	2,634	25	0	0	72	0	13
14	15	Other	Beds	2,634	25	0	0	72	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	72	50,184	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	72	5,345	16
17	19	Professional Services	Beds	2,634	25	199,226	0	72	5,446	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	72	4,845	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	72	112,602	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	72	23,012	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	72	491	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	72	7,205	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	72	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	72	8,001	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 235,913	25

Facility Name & ID Number Heritage Manor-Minonk

# 0048058

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	2,634	72	\$	\$	72	\$	1
2	30	Depreciation	Beds	2,634	72	281,453		72	7,693	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	72			72		3
4	32	Interest	Beds	2,634	72	169,367		72	4,630	4
5	33	Real Estate Taxes	Beds	2,634	72			72		5
6	34	Rent-Facility & Grounds	Beds	2,634	72	285,687		72	7,809	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	72	48,715		72	1,332	7
8	36	Other	Beds	2,634	72			72		8
9	38	Medically Nec Transportation	Beds	2,634	72			72		9
10	39	Ancillary Service Centers	Beds	2,634	72			72		10
11	40	Barber and Beauty Shops	Beds	2,634	72			72		11
12	41	Coffee and Gift Shops	Beds	2,634	72			72		12
13	42	Other	Beds	2,634	72			72		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 785,222	\$		\$ 21,464	25

Facility Name & ID Number Heritage Manor-Minonk # 0048058 Report Period Beginning: 01/01/08 Ending: 12/31/08

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Bank of America		xx	Mortgage			\$	\$ 981,669	03/11	variable	\$ 64,176	1
2	Bank of America		xx	Loan Fees							6,012	2
3	Bank of Springfield		xx	Van				61,667	10/13	6.0000	326	3
4												4
5												5
	<b>Working Capital</b>											
6	Bank of America		xx	Accounts Receivable							7,336	6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$ 1,043,336			\$ 77,850	9
	<b>B. Non-Facility Related*</b>											
10	Interest Income										(1,864)	10
11	Allocated Corporate										4,630	11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 2,766	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 1,043,336			\$ 80,616	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none 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><b>Important</b>, 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 2007 report.		\$	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.)		\$ <b>34,664</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>34,664</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>34,664</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	<u>38,094</u>	<u>8</u>
	2004	<u>35,421</u>	<u>9</u>
	2005	<u>26,483</u>	<u>10</u>
	2006	<u>34,546</u>	<u>11</u>
	2007	<u>34,664</u>	<u>12</u>
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor-Minonk COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0048058

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 2007 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 2007.

(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>0607407010</u>	_____	\$ <u>11,078.00</u>	\$ <u>11,078.00</u>
2. <u>0607407011</u>	_____	\$ <u>23,586.00</u>	\$ <u>23,586.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>34,664.00</u>	\$ <u>34,664.00</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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-Minonk

# 0048058 Report Period Beginning:

01/01/08 Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 7,560 B. General Construction Type: Exterior brick Frame wood Number of Stories \_\_\_\_\_

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>25,000</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>25,000</u>	3

Facility Name &amp; ID Number Heritage Manor-Minonk

# 0048058

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	72				\$ 1,039,908	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		Smoke Detectors (45)		1998	3,267						9
10		Compressor		1998	1,047						10
11		Generator		1998	12,140						11
12		A/C Repair		1998	1,518						12
13		Plumbing Repair		1998	4,956						13
14											14
15		Water Heater		1996	2,603						15
16		Resident Room Renovating		1996	8,483						16
17		Exterior Painting & Renovation		1996	4,806						17
18		Nurse Call System		1996	3,803						18
19		Garbage Disposal		1996	867						19
20		Boiler Repair		1996	4,436						20
21		Receptionist Work Area Renovation		1996	1,260						21
22		Hot Water Heater		1996	505						22
23		Exterior Signage		1996	1,680						23
24		Interior Rehab		1996	146,288						24
25		Interior Rehab		1996	22,963						25
26		Code Alert System		1996	1,319						26
27											27
28		Interior Rehab		1997	33,578						28
29		Interior Rehab		1997	168						29
30		Building Purchase Offset		1997	(141,199)						30
31											31
32											32
33											33
34		C/O Allocation						7,693	7,693		34
35		Book Depreciation				55,618		55,618		522,633	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Minonk# 0048058

Report Period Beginning:

01/01/08

Ending:

12/31/08**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Door Alarm System	1999	\$ 10,116	\$		\$	\$	\$	37
38	Plumbing / Water Heater	1999	3,170						38
39	Sewage Ejector	1999	3,042						39
40									40
41	Water Heater	2000	3,293						41
42	Remove and replace patio	2000	5,890						42
43									43
44	Garbage Disposal	2001	922						44
45	Painting--Hallways/Resident rooms	2001	2,444						45
46									46
47	Water Faucet	2002	1,656						47
48	Boiler	2002	17,945						48
49	Shower Faucet	2002	2,398						49
50									50
51	Roof	2003	30,757						51
52	Faucets	2003	1,915						52
53	Compressor	2003	1,126						53
54	Disposal	2003	970						54
55									55
56	Water Heater	2004	3,889						56
57	Hot Water Storage Tank	2004	1,744						57
58	Ansul System	2004	1,455						58
59	Door Alarm System	2004	10,914						59
60	Heat Exchanger	2004	1,518						60
61									61
62	Sewage Ejector	2005	3,310						62
63	Circulator Motor	2005	892						63
64	Dry Valve	2005	2,410						64
65	Integrety Bather	2005	827						65
66	Exterior Doors	2005	6,106						66
67	Sprinkler Repair	2005	2,957						67
68	Glass Door	2005	361						68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,276,423	\$ 55,618		\$ 63,311	\$ 7,693	\$ 522,633	70

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

Facility Name & ID Number Heritage Manor-Minonk

# 0048058

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,276,423	\$ 55,618		\$ 63,311	\$ 7,693	\$ 522,633	1
2	Climate Control	2006	1,299						2
3	Shower Faucet	2006	444						3
4	Sprinkler main line	2006	6,672						4
5	Compressor	2006	1,580						5
6	Corridor Rehab	2006	5,855						6
7	Rooftop A/C	2006	8,235						7
8									8
9	Fire Alarm	2007	39,698						9
10	Chiller	2007	11,569						10
11	Bearing Assembly	2007	1,109						11
12	Sprinkler	2007	2,180						12
13	HVAC	2007	876						13
14	Landscaping	2007	9,585						14
15	Thermostat	2007	7,722						15
16									16
17	Nurse Call System	2008	125,184						17
18	Soffit & Facia	2008	14,880						18
19	Water Heater	2008	9,193						19
20	Wonderguard	2008	8,777						20
21	Wireless phone system	2008	22,250						21
22	Cables for Nurse Call system	2008	9,897						22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,563,428	\$ 55,618		\$ 63,311	\$ 7,693	\$ 522,633	34

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

Facility Name & ID Number Heritage Manor-Minonk

# 0048058

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	\$ 1,563,428	\$ 55,618		\$ 63,311	\$ 7,693	\$ 522,633		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,563,428	\$ 55,618		\$ 63,311	\$ 7,693	\$ 522,633		34

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

Facility Name & ID Number Heritage Manor-Minonk

# 0048058

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 1,563,428	\$ 55,618		\$ 63,311	\$ 7,693	\$ 522,633	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 1,563,428	\$ 55,618		\$ 63,311	\$ 7,693	\$ 522,633	34

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

Facility Name & ID Number Heritage Manor-Minonk # 0048058 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	\$ 232,393	\$ 16,301	\$ 16,301	\$		\$ 194,106	71
72	Current Year Purchases	30,653						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 263,046	\$ 16,301	\$ 16,301	\$		\$ 194,106	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		2009 Turtletop Van	2008	\$ 61,815	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 61,815	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,913,289	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,919	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 79,612	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,693	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 716,739	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 1,553 Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		110		110
3	Classroom Wages (a)				
4	Clinical Wages (b)		2,063		2,063
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 2,173	\$	\$ 2,173
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	2,173		

**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.

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## 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	\$		\$ 106,781	\$		\$ 106,781	1
2	Licensed Speech and Language Development Therapist		hrs			9,506			9,506	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			100,009	1,005		101,014	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				203,491		203,491	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					8,524			8,524	13
14	TOTAL			\$		\$ 224,820	\$ 204,496		\$ 429,316	14

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

Facility Name & ID Number Heritage Manor-Minonk # 0048058 Report Period Beginning: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 2,151	\$	1
2	Cash-Patient Deposits	5,920		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	258,158		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,245		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(83,399)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 187,075	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 187,075	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 82,114	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,920		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	173,468		30
31	Accrued Taxes Payable (excluding real estate taxes)	607		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>IPA Tax</u>	6,762		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 268,871	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			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>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 268,871	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (81,796)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 187,075	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (65,154)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (65,154)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(16,642)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (16,642)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (81,796)	24 *

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

Facility Name & ID Number Heritage Manor-Minonk# 0048058Report Period Beginning: 01/01/08Ending: 12/31/08**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	\$ 3,207,839	1
2	Discounts and Allowances for all Levels	(994,647)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,213,192	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	753,419	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 753,419	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	2,817	12
13	Barber and Beauty Care	2,615	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	343,116	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,977	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 355,525	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,864	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,864	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>	\$ 3,324,000	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	698,126	31
32	Health Care	1,580,031	32
33	General Administration	738,230	33
<b>B. Capital Expense</b>			
34	Ownership	324,249	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	6	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>	\$ 3,340,642	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(16,642)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (16,642)	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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,992	2,080	\$ 55,049	\$ 26.47	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	10,028	10,912	264,936	24.28	3
4	Licensed Practical Nurses	5,024	5,508	126,882	23.04	4
5	CNAs & Orderlies	39,356	42,047	504,653	12.00	5
6	CNA Trainees			2,063		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,526	1,714	18,244	10.64	8
9	Activity Director					9
10	Activity Assistants	4,978	5,445	55,695	10.23	10
11	Social Service Workers	1,798	2,100	33,710	16.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,665	19,663	196,542	10.00	15
16	Dishwashers					16
17	Maintenance Workers	3,419	3,959	54,792	13.84	17
18	Housekeepers	7,219	8,161	77,570	9.50	18
19	Laundry	4,835	5,468	51,163	9.36	19
20	Administrator	1,900	2,080	74,118	35.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,485	6,087	93,486	15.36	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)	106,225	115,224	\$ 1,608,903 *	\$ 13.96	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		1,025		36
37	Medical Records Consultant		1,690		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,160		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,155		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 7,030		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	216	\$ 8,646		50
51	Licensed Practical Nurses	117	4,109		51
52	Certified Nurse Assistants/Aides		0		52
53	TOTAL (lines 50 - 52)	334	\$ 12,755		53

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**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kim Seaman	admin	0	\$ 74,118	Workers' Compensation Insurance	\$ 54,941	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	21,151	Advertising: Employee Recruitment	3,680	
				FICA Taxes	123,081	Health Care Worker Background Check		
				Employee Health Insurance	101,115	(Indicate # of checks performed)	660	
				Employee Meals		Patient Background Checks	4,845	
				Illinois Municipal Retirement Fund (IMRF)*			13,600	
					0		4,236	
					15,684	Dues & Subscriptions	4,772	
					23,012	License & Fees	3,276	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 74,118			Less: Public Relations Expense	(4,236)	
(List each licensed administrator separately.)						Non-allowable advertising	(346)	
						Yellow page advertising	(13,600)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
								5,465
								28
							Seminar Expense	4,189
								(14,888)
							Central Office	7,205
							Entertainment Expense	( )
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			line 24, col. 8)	\$ 1,999
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type	Amount						
Heritage Operations Group	Mgt Fee	\$ 146,970						
		0						
		0						
		0						
		0						
legal		2,853						
		0						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 149,823					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES x 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 Minonk 38364 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 26,828  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 5,077
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? 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? yes
- g. Does the facility transport residents to and from day training? no**  
**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? \_\_\_\_\_ 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.



