



Facility Name & ID Number Heritage Manor-Streator# 0048066 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>130</u>	Skilled (SNF)	<u>130</u>	<u>47,450</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>130</u>	TOTALS	<u>130</u>	<u>47,450</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>24,646</u>	<u>15,409</u>	<u>4,043</u>	<u>44,098</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>24,646</u>	<u>15,409</u>	<u>4,043</u>	<u>44,098</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.94%

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 4,043Medicare Intermediary WPS

## IV. ACCOUNTING BASIS

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

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

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

Facility Name & ID Number Heritage Manor-Streator # 0048066 Report Period Beginning: 01/01/08 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	273,591	17,751		291,342		291,342	7,155	298,497		1
2	Food Purchase		233,606		233,606		233,606		233,606		2
3	Housekeeping	130,214	20,849		151,063		151,063	27	151,090		3
4	Laundry	58,528	18,705		77,233		77,233		77,233		4
5	Heat and Other Utilities			150,521	150,521		150,521	2,518	153,039		5
6	Maintenance	101,621	80,785	41,224	223,630		223,630	17,920	241,550		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>563,954</b>	<b>371,696</b>	<b>191,745</b>	<b>1,127,395</b>		<b>1,127,395</b>	<b>27,620</b>	<b>1,155,015</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			400	400		400	2,921	3,321		9
10	Nursing and Medical Records	2,329,204	185,490	14,825	2,529,519		2,529,519		2,529,519		10
10a	Therapy		352,058	446,966	799,024	(383,783)	415,241	318,063	733,304		10a
11	Activities	89,220	5,080		94,300		94,300	1,881	96,181		11
12	Social Services	42,650	775	2,566	45,991		45,991		45,991		12
13	CNA Training	9,291	1,587		10,878		10,878	1,487	12,365		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,470,365</b>	<b>544,990</b>	<b>464,757</b>	<b>3,480,112</b>	<b>(383,783)</b>	<b>3,096,329</b>	<b>324,352</b>	<b>3,420,681</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	98,585			98,585		98,585	90,609	189,194		17
18	Directors Fees							9,651	9,651		18
19	Professional Services			321,876	321,876		321,876	(312,043)	9,833		19
20	Dues, Fees, Subscriptions & Promotions			110,967	110,967	(71,175)	39,792	(10,970)	28,822		20
21	Clerical & General Office Expenses	168,963	22,625	5,904	197,492		197,492	203,310	400,802		21
22	Employee Benefits & Payroll Taxes			616,641	616,641		616,641	41,549	658,190		22
23	Inservice Training & Education			3,689	3,689		3,689	(1,690)	1,999		23
24	Travel and Seminar			10,512	10,512		10,512	(8,513)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			61,095	61,095		61,095	14,446	75,541		26
27	Other (specify):*			6,480	6,480		6,480	(6,480)			27
28	<b>TOTAL General Administration</b>	<b>267,548</b>	<b>22,625</b>	<b>1,137,164</b>	<b>1,427,337</b>	<b>(71,175)</b>	<b>1,356,162</b>	<b>19,869</b>	<b>1,376,031</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,301,867</b>	<b>939,311</b>	<b>1,793,666</b>	<b>6,034,844</b>	<b>(454,958)</b>	<b>5,579,886</b>	<b>371,841</b>	<b>5,951,727</b>		<b>29</b>

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

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

Facility Name & ID Number Heritage Manor-Streator #0048066 Report Period Beginning: 01/01/08 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							236,367	236,367			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,922	17,922		17,922	238,373	256,295			32
33	Real Estate Taxes							56,544	56,544			33
34	Rent-Facility & Grounds			525,600	525,600		525,600	(511,500)	14,100			34
35	Rent-Equipment & Vehicles			7,546	7,546		7,546	2,404	9,950			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			551,068	551,068		551,068	22,188	573,256			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					383,783	383,783		383,783			39
40	Barber and Beauty Shops		857	19,258	20,115		20,115		20,115			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					71,175	71,175		71,175			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		857	19,258	20,115	454,958	475,073		475,073			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,301,867	940,168	2,363,992	6,606,027		6,606,027	394,029	7,000,056			45

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

Facility Name & ID Number Heritage Manor-Streator

# 0048066

Report Period Beginning: 01/01/08

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	(3,566)	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)	(2,577)	23		16
17	Non-Care Related Fees	(1,096)	20		17
18	Fines and Penalties				18
19	Entertainment	(21,523)	24		19
20	Contributions	(480)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(650)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	27		24
25	Fund Raising, Advertising and Promotional	(18,622)	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>	\$ (54,514)		\$	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)	448,543		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 448,543		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 394,029		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-Streator

ID# 0048066

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		(2,577)	23
17		(1,096)	20
18			18
19			24
20		(480)	27
21			21
22		(650)	19
23			23
24		(6,000)	27
25		(18,622)	20
26			26
27			27
28			28
29		0	33
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(29,425)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Streator

# 0048066

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	7,155	0	0	0	0	0	0	0	0	7,155	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	27	0	0	0	0	0	0	0	0	27	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,518	0	0	0	0	0	0	0	0	2,518	5
6	Maintenance	0	0	17,920	0	0	0	0	0	0	0	0	17,920	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	27,620	0	0	0	0	0	0	0	0	27,620	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	2,921	0	0	0	0	0	0	0	0	2,921	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	318,063	0	0	0	0	0	0	0	0	0	318,063	10a
11	Activities	0	0	1,881	0	0	0	0	0	0	0	0	1,881	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,487	0	0	0	0	0	0	0	0	1,487	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	318,063	6,289	0	0	0	0	0	0	0	0	324,352	16
	<b>C. General Administration</b>													
17	Administrative	0	0	90,609	0	0	0	0	0	0	0	0	90,609	17
18	Directors Fees	0	0	9,651	0	0	0	0	0	0	0	0	9,651	18
19	Professional Services	(650)	(321,226)	9,833	0	0	0	0	0	0	0	0	(312,043)	19
20	Fees, Subscriptions & Promotions	(19,718)	0	8,748	0	0	0	0	0	0	0	0	(10,970)	20
21	Clerical & General Office Expenses	0	0	203,310	0	0	0	0	0	0	0	0	203,310	21
22	Employee Benefits & Payroll Taxes	0	0	41,549	0	0	0	0	0	0	0	0	41,549	22
23	Inservice Training & Education	(2,577)	0	887	0	0	0	0	0	0	0	0	(1,690)	23
24	Travel and Seminar	(21,523)	0	13,010	0	0	0	0	0	0	0	0	(8,513)	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	14,446	0	0	0	0	0	0	0	0	14,446	26
27	Other (specify):*	(6,480)	0	0	0	0	0	0	0	0	0	0	(6,480)	27
28	<b>TOTAL General Administration</b>	(50,948)	(321,226)	392,043	0	0	0	0	0	0	0	0	19,869	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(50,948)	(3,163)	425,952	0	0	0	0	0	0	0	0	371,841	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Streator

# 0048066

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	222,476	0	13,891	0	0	0	0	0	0	0	236,367	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,566)	233,580	0	8,359	0	0	0	0	0	0	0	238,373	32
33	Real Estate Taxes	0	56,544	0	0	0	0	0	0	0	0	0	56,544	33
34	Rent-Facility & Grounds	0	(525,600)	0	14,100	0	0	0	0	0	0	0	(511,500)	34
35	Rent-Equipment & Vehicles	0	0	0	2,404	0	0	0	0	0	0	0	2,404	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,566)</b>	<b>(13,000)</b>	<b>0</b>	<b>38,754</b>	<b>0</b>	<b>22,188</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>(54,514)</b>	<b>(16,163)</b>	<b>425,952</b>	<b>38,754</b>	<b>0</b>	<b>394,029</b>	<b>45</b>						

**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		318,063	318,063
3	V						
4	V	19	Adjustment for Related Organization	Heritage Operations Group, LLC	0.00%		(321,226)
5	V						
6	V	34	Adjustment for Related Organization	Heritage Manor Real Estate, LLC	0.00%		(525,600)
7	V	33	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		56,544	56,544
8	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		222,623	222,623
9	V	30	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		222,476	222,476
10	V	32	Adjustment for Related Organization	Heritage Manor Real Estate, LLC		10,957	10,957
11	V						
12	V						
13	V						
14	Total		\$ 846,826			\$ 830,663	\$ * (16,163)

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

Facility Name & ID Number Heritage Manor-Streator# 0048066Report Period Beginning: 01/01/08Ending: 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	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.	0.00%	\$ 7,155	\$ 7,155	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				27	27	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				2,518	2,518	19
20	V	6 Maintenance				17,920	17,920	20
21	V	7 Other				0		21
22	V	9 Medical Director				2,921	2,921	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,881	1,881	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				1,487	1,487	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				90,609	90,609	29
30	V	18 Directors Fees				9,651	9,651	30
31	V	19 Professional Services				9,833	9,833	31
32	V	20 Fees, Subscription, Promotions				8,748	8,748	32
33	V	21 Clerical & General Office Expenses				203,310	203,310	33
34	V	22 Employee Benefits & Payroll Taxes				41,549	41,549	34
35	V	23 Inservice Training & Education				887	887	35
36	V	24 Travel and Seminar				13,010	13,010	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				14,446	14,446	38
39	Total		\$			\$ 425,952	\$ * 425,952	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				13,891		13,891
17	V	31 Amortization of Pre-Op & Org				0		0
18	V	32 Interest				8,359		8,359
19	V	33 Real Estate Taxes				0		0
20	V	34 Rent-Facility & Grounds				14,100		14,100
21	V	35 Rent-Equipment & Vehicles				2,404		2,404
22	V	36 Other				0		0
23	V	38 Medically Nec Transportation				0		0
24	V	39 Ancillary Service Centers				0		0
25	V	40 Barber and Beauty Shops				0		0
26	V	41 Coffee and Gift Shops				0		0
27	V	42 Other				0		0
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$			\$ 38,754	\$ *	38,754

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

Facility Name & ID Number Heritage Manor-Streator # 0048066 Report Period Beginning: 01/01/08 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					\$ 9,651	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	\$ 9,651		13

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

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

Facility Name & ID Number Heritage Manor-Streator

# 0048066

Report Period Beginning: 01/01/08

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	130	\$ 7,155	1
2	2	Food Purchase	Beds	2,634	25	0	0	130	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	130	27	3
4	4	Laundry	Beds	2,634	25	0	0	130	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	130	2,518	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	130	17,920	6
7	7	Other	Beds	2,634	25	0	0	130	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	130	2,921	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	130	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	130	1,881	10
11	12	Social Service	Beds	2,634	25	0	0	130	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	130	1,487	12
13	14	Program Transportation	Beds	2,634	25	0	0	130	0	13
14	15	Other	Beds	2,634	25	0	0	130	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	130	90,609	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	130	9,651	16
17	19	Professional Services	Beds	2,634	25	199,226	0	130	9,833	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	130	8,748	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	130	203,310	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	130	41,549	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	130	887	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	130	13,010	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	130	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	130	14,446	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 425,952	25

Facility Name & ID Number Heritage Manor-Streator

# 0048066

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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	130	\$	\$	130	\$	1
2	30	Depreciation	Beds	2,634	130	281,453		130	13,891	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	130			130		3
4	32	Interest	Beds	2,634	130	169,367		130	8,359	4
5	33	Real Estate Taxes	Beds	2,634	130			130		5
6	34	Rent-Facility & Grounds	Beds	2,634	130	285,687		130	14,100	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	130	48,715		130	2,404	7
8	36	Other	Beds	2,634	130			130		8
9	38	Medically Nec Transportation	Beds	2,634	130			130		9
10	39	Ancillary Service Centers	Beds	2,634	130			130		10
11	40	Barber and Beauty Shops	Beds	2,634	130			130		11
12	41	Coffee and Gift Shops	Beds	2,634	130			130		12
13	42	Other	Beds	2,634	130			130		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	\$		\$ 38,754	25

Facility Name &amp; ID Number

Heritage Manor-Streator

# 0048066

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			\$	\$ 3,389,643	03/11	variable	\$ 222,297	1
2	Bank of America		xx	Loan Fees							10,957	2
3	Bank of Springfield		xx	Van						variable	326	3
4												4
5												5
<b>Working Capital</b>												
6	Bank of America		xx	Accounts Receivable							17,922	6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$	\$ 3,389,643			\$ 251,502	9
<b>B. Non-Facility Related*</b>												
10	Interest Income										(3,566)	10
11	Allocated Corporate										8,359	11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 4,793	14
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 3,389,643			\$ 256,295	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

1. Real Estate Tax accrual used on 2007 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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.)			\$ 56,544	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 56,544	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.			\$ 56,544	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
2003	46,194	8		
2004	45,092	9		
2005	57,575	10		
2006	71,142	11		
2007	56,544	12		
			<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-Streator COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0048066

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 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>34-31-112-000</u>	_____	\$ <u>56,544.00</u>	\$ <u>56,544.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>56,544.00</u>	\$ <u>56,544.00</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-Streator

# 0048066 Report Period Beginning:

01/01/08 Ending:

12/31/08

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 19,262 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>17,000</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>17,000</u>	3

Facility Name & ID Number Heritage Manor-Streator# 0048066

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	130				\$ 348,848	\$		\$	\$	\$	4
5					440,122						5
6					2,594,839						6
7											7
8											8
	<b>Improvement Type**</b>										
9	1978 Improvements			1980	12,172						9
10	1979 Improvements			1981	13,748						10
11	1980 Improvements			1982	18,366						11
12	1981 Improvements			1983	9,250						12
13	1982 Improvements			1984	1,329						13
14	1983 Improvements			1985	4,100						14
15	1984 Improvements			1986	57,336						15
16	1985 Improvements			1987	6,225						16
17	1986 Improvements			1988	48,818						17
18	1988 Improvements			1989	22,687						18
19	1989 Improvements			1990	31,584						19
20	1990 Improvements			1991	3,560						20
21	1991 Improvements			1992	19,172						21
22	1992 Improvements			1993	23,135						22
23	1993 Improvements			1994	22,036						23
24	1994 Improvements			1995	39,228						24
25	1995 Improvements			1996	3,910						25
26	BOILER										26
27	EXHAUST HOOD										27
28	CODE ALERT										28
29	PHONE SYSTEM										29
30	INTERIOR REMODEL										30
31											31
32											32
33											33
34	C/O Allocation							13,891	13,891		34
35	Book Depreciation					157,680		157,680		1,126,649	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Streator# 0048066

Report Period Beginning:

01/01/08

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	Interior Rehab---Facility	1997	\$ 286,974	\$		\$	\$	\$	37
38	Roof	1997	5,232						38
39	Sprinkler System	1997	9,530						39
40	Code Alert	1997	1,879						40
41									41
42	Code Alert	1998	2,000						42
43	Bathroom Door	1998	656						43
44	Interior Rehab	1998	11,815						44
45									45
46	Door Alarms	1999	3,675						46
47									47
48	Water Heater	2000	4,114						48
49	Exhaust Fans	2000	931						49
50	Booster Heater -- Water Heater	2000	1,465						50
51									51
52	Professional Fees---Building Renovation	2001	27,964						52
53	Sprinkler Replacement	2001	4,955						53
54	AC Unit with Installation	2001	4,372						54
55	Exterior Painting	2001	6,545						55
56	Code Alert System	2001	4,592						56
57									57
58	Roof	2002	48,840						58
59	Sewer line	2002	20,615						59
60	Condensing Unit	2002	1,213						60
61									61
62	Exterior Door	2003	6,556						62
63	Exit Lights	2003	1,013						63
64	Heating Pump	2003	1,746						64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 4,177,147	\$ 157,680		\$ 171,571	\$ 13,891	\$ 1,126,649	70

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

Facility Name &amp; ID Number Heritage Manor-Streator

# 0048066

Report Period Beginning:

01/01/08

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	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,177,147	\$ 157,680		\$ 171,571	\$ 13,891	\$ 1,126,649	1
2	Doors	2004	1,386						2
3	A/C	2004	5,061						3
4	PVC kickplate	2004	2,859						4
5	Disposal	2004	1,175						5
6									6
7	Roof	2005	54,596						7
8	A/C Condensing Unit	2005	5,800						8
9	Window Replacement	2005	51,893						9
10	Water Main	2005	1,706						10
11									11
12									12
13	Roof	2006	19,500						13
14	A/C Replacement	2006	1,974						14
15	Boiler	2006	58,327						15
16	Landscapping	2006	5,398						16
17									17
18		2007	9,580						18
19	Nurse's station	2007	96,193						19
20	Nurse call system	2007	26,272						20
21	Wireless network	2007	37,819						21
22	Corridor Paint and floors	2007	23,747						22
23	A/C	2007	4,177						23
24	Wander guard	2007	42,453						24
25	Garage	2007	1,286						25
26	Professional Fee -- remodel								26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,628,349	\$ 157,680		\$ 171,571	\$ 13,891	\$ 1,126,649	34

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

Facility Name & ID Number Heritage Manor-Streator

# 0048066

Report Period Beginning:

01/01/08

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		\$ 4,628,349	\$ 157,680		\$ 171,571	\$ 13,891	\$ 1,126,649	1
2	Landscaping	2008	22,238						2
3	Garage	2008	9,644						3
4	South Wing Windows	2008	63,040						4
5	Air Handler	2008	10,301						5
6	Redo North Nurses Station	2008	8,101						6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,741,673	\$ 157,680		\$ 171,571	\$ 13,891	\$ 1,126,649	34

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

Facility Name & ID Number Heritage Manor-Streator

# 0048066

Report Period Beginning:

01/01/08

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		\$ 4,741,673	\$ 157,680		\$ 171,571	\$ 13,891	\$ 1,126,649	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,741,673	\$ 157,680		\$ 171,571	\$ 13,891	\$ 1,126,649	34

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

Facility Name & ID Number Heritage Manor-Streator # 0048066 Report Period Beginning: 01/01/08 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	\$ 1,043,337	\$ 64,796	\$ 64,796	\$		\$ 806,964	71
72	Current Year Purchases	93,820						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,137,157	\$ 64,796	\$ 64,796	\$		\$ 806,964	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)	\$ 5,895,830	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 222,476	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 236,367	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,891	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,933,613	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	\$ 0
13.	/2010	\$ 0
14.	/2011	\$ 0

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

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

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

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

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

YES  NO

16. Rental Amount for movable equipment: \$ 7,546 Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		1,587		1,587
3	Classroom Wages (a)				
4	Clinical Wages (b)		9,291		9,291
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 10,878	\$	\$ 10,878
10	SUM OF line 9, col. 1 and 2 (e)	\$	10,878		

**C. CONTRACTUAL INCOME**

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

\$ \_\_\_\_\_

**D. NUMBER OF CNAs TRAINED**

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

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

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

Facility Name & ID Number Heritage Manor-Streator# 0048066 Report Period Beginning:01/01/08 Ending:12/31/08

## 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	\$		\$ 168,019	\$		\$ 168,019	1
2	Licensed Speech and Language Development Therapist		hrs			36,105			36,105	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			206,958	4,159		211,117	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				347,899		347,899	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					35,884			35,884	13
14	TOTAL			\$		\$ 446,966	\$ 352,058		\$ 799,024	14

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

Facility Name & ID Number Heritage Manor-Streator# 0048066Report Period Beginning: 01/01/08

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	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 3,922	\$	1
2	Cash-Patient Deposits	6,622		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,115,624		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,613		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(528,402)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 628,379	\$	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>	\$ 628,379	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 223,165	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,622		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	325,482		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,825		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>	17,940		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 579,034	\$	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>	\$ 579,034	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 49,345	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 628,379	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (488,178)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (488,178)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	537,523	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)	\$ 537,523	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)	\$ 49,345	24 *

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

Facility Name & ID Number Heritage Manor-Streator# 0048066Report 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	\$ 6,906,943	1
2	Discounts and Allowances for all Levels	(1,814,753)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,092,190	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,401,499	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,401,499	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	2,299	11
12	Gift and Coffee Shop	1,138	12
13	Barber and Beauty Care	25,941	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	609,894	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	7,023	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 646,295	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,566	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,566	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>	\$ 7,143,550	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,127,395	31
32	Health Care	3,480,112	32
33	General Administration	1,427,337	33
<b>B. Capital Expense</b>			
34	Ownership	551,068	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	20,115	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>	\$ 6,606,027	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	537,523	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 537,523	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-Streator

# 0048066

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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	2,085	2,085	\$ 52,838	\$ 25.34	1
2	Assistant Director of Nursing	2,880	2,880	61,295	21.28	2
3	Registered Nurses	13,658	13,658	363,691	26.63	3
4	Licensed Practical Nurses	22,413	22,413	507,746	22.65	4
5	CNAs & Orderlies	110,394	110,394	1,323,316	11.99	5
6	CNA Trainees	100	100	9,291	92.91	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	850	850	20,318	23.90	8
9	Activity Director					9
10	Activity Assistants	8,022	8,022	89,220	11.12	10
11	Social Service Workers	3,354	3,354	42,650	12.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,202	28,202	273,591	9.70	15
16	Dishwashers					16
17	Maintenance Workers	8,137	8,137	101,621	12.49	17
18	Housekeepers	14,934	14,934	130,214	8.72	18
19	Laundry	5,945	5,945	58,528	9.84	19
20	Administrator	2,080	2,080	98,585	47.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,473	12,473	168,963	13.55	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)	235,527	235,527	\$ 3,301,867 *	\$ 14.02	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		400		36
37	Medical Records Consultant		200		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,300		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,566		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 6,466		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		0		52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Heritage Manor-Streator

# 0048066

Report Period Beginning: 01/01/08

Ending: 12/31/08

**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	
Janet Strabala	admin	0	\$ 98,585	Workers' Compensation Insurance	\$ 68,053	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	36,800	Advertising: Employee Recruitment	8,298	
				FICA Taxes	252,593	Health Care Worker Background Check (Indicate # of checks performed )	1,490	
				Employee Health Insurance	239,309	Patient Background Checks	8,748	
				Employee Meals			13,600	
				Illinois Municipal Retirement Fund (IMRF)*			6,245	
					0	Dues & Subscriptions	8,277	
					19,886	License & Fees	2,110	
					41,549			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 98,585			Less: Public Relations Expense	(6,245)	
B. Administrative - Other						Non-allowable advertising	(1,096)	
Description			Amount			Yellow page advertising	(13,600)	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 658,190	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,822	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Heritage Operations Group	Mgt Fee		\$ 321,226			\$	Out-of-State Travel	\$
			0					
			0				In-State Travel	
			0					6,770
								438
							Seminar Expense	3,304
								(21,523)
			0				Central Office	13,010
legal adjustment			650				Entertainment Expense	( )
			0				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 321,876	TOTAL		\$	TOTAL	\$ 1,999

\* 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 Streator 38349 07/2006
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 71,175  
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. \$ 20,937
- (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.

Room

