



Facility Name & ID Number Heritage Manor-Mount Zion

# 0044073 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

**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	75	Skilled (SNF)	75	27,375	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	15,487	310	3,262	19,059	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	3,816	0	3,816	12
13	DD 16 OR LESS					13
14	TOTALS	15,487	4,126	3,262	22,875	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.56%

D. How many bed-hold days during this year were paid by Public Aid? 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)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 10/01/98

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 3,262

Medicare Intermediary \_\_\_\_\_

**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.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	129,665	9,861		139,526		139,526	1,936	141,462		1
2	Food Purchase		100,344		100,344		100,344		100,344		2
3	Housekeeping	74,932	10,662		85,594		85,594		85,594		3
4	Laundry	26,577	7,237		33,814		33,814		33,814		4
5	Heat and Other Utilities			66,204	66,204		66,204	859	67,063		5
6	Maintenance	28,756	22,462	14,221	65,439		65,439	8,616	74,055		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	259,930	150,566	80,425	490,921		490,921	11,411	502,332		8
<b>B. Health Care and Programs</b>											
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	834,549	79,579	3,938	918,066		918,066		918,066		10
10a	Therapy		154,592	200,460	355,052	(335,110)	19,942	159,587	179,529		10a
11	Activities	21,990	3,488		25,478		25,478		25,478		11
12	Social Services	28,569		5,752	34,321		34,321		34,321		12
13	Nurse Aide Training	1,101	474		1,575		1,575	1,331	2,906		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	886,209	238,133	228,150	1,352,492	(335,110)	1,017,382	160,918	1,178,300		16
<b>C. General Administration</b>											
17	Administrative	54,325			54,325		54,325	53,389	107,714		17
18	Directors Fees							4,842	4,842		18
19	Professional Services			184,451	184,451		184,451	(176,295)	8,156		19
20	Dues, Fees, Subscriptions & Promotions			82,483	82,483	(41,063)	41,420	(6,950)	34,470		20
21	Clerical & General Office Expenses	84,622	8,928	14,303	107,853		107,853	151,154	259,007		21
22	Employee Benefits & Payroll Taxes			231,345	231,345		231,345	21,678	253,023		22
23	Inservice Training & Education			1,413	1,413		1,413	586	1,999		23
24	Travel and Seminar			4,201	4,201		4,201	(2,202)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			37,726	37,726		37,726	1,494	39,220		26
27	Other (specify):*			24,070	24,070		24,070	(24,070)			27
28	<b>TOTAL General Administration</b>	138,947	8,928	579,992	727,867	(41,063)	686,804	23,626	710,430		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,285,086	397,627	888,567	2,571,280	(376,173)	2,195,107	195,955	2,391,062		29

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

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

Facility Name &amp; ID Number

Heritage Manor-Mount Zion

#0044073

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			203,142	203,142		203,142	7,448	210,590			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			109,878	109,878		109,878	6,545	116,423			32
33	Real Estate Taxes			64,304	64,304		64,304		64,304			33
34	Rent-Facility & Grounds							4,532	4,532			34
35	Rent-Equipment & Vehicles			4,698	4,698		4,698	6,925	11,623			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			382,022	382,022		382,022	25,450	407,472			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					335,110	335,110		335,110			39
40	Barber and Beauty Shops		71	5,520	5,591		5,591		5,591			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					41,063	41,063		41,063			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		71	5,520	5,591	376,173	381,764		381,764			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,285,086	397,698	1,276,109	2,958,893		2,958,893	221,405	3,180,298			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-Mount Zion

# 0044073

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

**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	OHF 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	(549)	35		5
6	Rented Facility Space	(445)	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	(38)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(435)	20		17
18	Fines and Penalties				18
19	Entertainment	(6,417)	24		19
20	Contributions	(70)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,055)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,000)	27		24
25	Fund Raising, Advertising and Promotional	(9,105)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (51,114)		\$	30

OHF USE ONLY					
48		49	50	51	52

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)	272,519		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 272,519		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 221,405		37

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

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

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

Heritage Manor-Mount Zion

ID# 0044073  
 Report Period Beginning: 01/01/2003  
 Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		(549)	35
6		(445)	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(435)	20
18			18
19			24
20		(70)	27
21			21
22		(10,055)	19
23			23
24		(24,000)	27
25		(9,105)	20
26			26
27			27
28			28
29			29
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>	(44,659)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Mount Zion

# 0044073

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## 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	1,936	0	0	0	0	0	0	0	0	1,936	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	859	0	0	0	0	0	0	0	0	859	5
6	Maintenance	0	0	8,616	0	0	0	0	0	0	0	0	8,616	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	11,411	0	0	0	0	0	0	0	0	11,411	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	159,587	0	0	0	0	0	0	0	0	0	159,587	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,331	0	0	0	0	0	0	0	0	1,331	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	159,587	1,331	0	0	0	0	0	0	0	0	160,918	16
	<b>C. General Administration</b>													
17	Administrative	0	0	53,389	0	0	0	0	0	0	0	0	53,389	17
18	Directors Fees	0	0	4,842	0	0	0	0	0	0	0	0	4,842	18
19	Professional Services	(10,055)	(174,396)	8,156	0	0	0	0	0	0	0	0	(176,295)	19
20	Fees, Subscriptions & Promotions	(9,540)	0	2,590	0	0	0	0	0	0	0	0	(6,950)	20
21	Clerical & General Office Expenses	0	0	151,154	0	0	0	0	0	0	0	0	151,154	21
22	Employee Benefits & Payroll Taxes	0	0	21,678	0	0	0	0	0	0	0	0	21,678	22
23	Inservice Training & Education	0	0	586	0	0	0	0	0	0	0	0	586	23
24	Travel and Seminar	(6,417)	0	4,215	0	0	0	0	0	0	0	0	(2,202)	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	1,494	0	0	0	0	0	0	0	0	1,494	26
27	Other (specify):*	(24,070)	0	0	0	0	0	0	0	0	0	0	(24,070)	27
28	<b>TOTAL General Administration</b>	(50,082)	(174,396)	248,104	0	0	0	0	0	0	0	0	23,626	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(50,082)	(14,809)	260,846	0	0	0	0	0	0	0	0	195,955	29



Facility Name & ID Number Heritage Manor-Mount Zion

# 0044073

Report Period Beginning: 01/01/2003 Ending: 12/31/2003

**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

**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		\$			\$	\$	1
2	V	10a Adjustment for Related Organization	107,436	GreenTree Therapy	100.00%	94,121	(13,315)	2
3	V							3
4	V	19 Adjustment for Related Organization	174,396	Heritage Enterprises, Inc.	100.00%		(174,396)	4
5	V							5
6	V	10a Adjustment for Related Organization	152,964	GreenTree Pharmacy	100.00%	325,866	172,902	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 434,796			\$ 419,987	\$ * (14,809)	14

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

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 1,936	\$ 1,936
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				859	859
20	V	6 Maintenance				8,616	8,616
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				1,331	1,331
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				53,389	53,389
30	V	18 Directors Fees				4,842	4,842
31	V	19 Professional Services				8,156	8,156
32	V	20 Fees, Subscription, Promotions				2,590	2,590
33	V	21 Clerical & General Office Expenses				151,154	151,154
34	V	22 Employee Benefits & Payroll Taxes				21,678	21,678
35	V	23 Inservice Training & Education				586	586
36	V	24 Travel and Seminar				4,215	4,215
37	V	25 Other Admin. Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				1,494	1,494
39	Total		\$			\$ 260,846	\$ * 260,846

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

Facility Name & ID Number Heritage Manor-Mount Zion

# 0044073

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

**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	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$	15	
16	V	30 Depreciation				7,448	7,448	16	
17	V	31 Amortization of Pre-Op & Org				0		17	
18	V	32 Interest				6,583	6,583	18	
19	V	33 Real Estate Taxes				0		19	
20	V	34 Rent-Facility & Grounds				4,977	4,977	20	
21	V	35 Rent-Equipment & Vehicles				7,474	7,474	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		\$			\$ 26,482	\$ *	26,482	39

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

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## 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	Bill Froelich	Director	Management	26.00	320,135	5	100.00	Director/Salar	\$ 9,992	line 17/18, col 1
2	Tom Jefferson	Secretary	Management	10.00	385,686	5	100.00	Director/Salary	12,038	line 17/18, col 2
3	Craig Hart	Chairman	Management	20.00	372,740	10	100.00	Director/Salary	11,634	line 17/18, col 3
4	Cheryl Lowney	Executive Vice Presi	Management	0.30	222,499	40	100.00	Director/Salary	6,944	line 17/18, col 4
5	Steve Wannemacher	President	Management	0.30	251,231	40	100.00	Director/Salary	7,841	line 17/18, col 5
6	Connie Hoselton	Sr Vice President	Management	0.20	148,865	40	100.00	Salary	4,646	line 17, col 7 6
7	Craig Ater	Sr Vice President	Management	0.20	164,565	40	100.00	Salary	5,136	line 17, col 7 7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 58,231	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-Mount Zion # 0044073 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

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	1	Dietary	Beds	2,403	24	\$ 62,023	75	\$ 1,936	1
2	2	Food Purchase	Beds	2,403	24	0	75	0	2
3	3	Housekeeping	Beds	2,403	24	0	75	0	3
4	4	Laundry	Beds	2,403	24	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,403	24	27,509	75	859	5
6	6	Maintenance	Beds	2,403	24	276,052	75	8,616	6
7	7	Other	Beds	2,403	24	0	75	0	7
8	9	Medical Director	Beds	2,403	24	0	75	0	8
9	10	Nursing & Medical Records	Beds	2,403	24	0	75	0	9
10	11	Activities	Beds	2,403	24	0	75	0	10
11	12	Social Service	Beds	2,403	24	0	75	0	11
12	13	Nurse Aide Training	Beds	2,403	24	42,658	75	1,331	12
13	14	Program Transportation	Beds	2,403	24	0	75	0	13
14	15	Other	Beds	2,403	24	0	75	0	14
15	17	Administrative	Beds	2,403	24	1,710,580	75	53,389	15
16	18	Directors Fees	Beds	2,403	24	155,144	75	4,842	16
17	19	Professional Services	Beds	2,403	24	261,316	75	8,156	17
18	20	Fees, Subscription, Promotions	Beds	2,403	24	82,980	75	2,590	18
19	21	Clerical & General Office Expense	Beds	2,403	24	4,842,980	75	151,154	19
20	22	Employee Benefits & Payroll Tax	Beds	2,403	24	694,554	75	21,678	20
21	23	Inservice Training & Education	Beds	2,403	24	18,789	75	586	21
22	24	Travel and Seminar	Beds	2,403	24	135,033	75	4,215	22
23	25	Other Admin. Staff Transportatio	Beds	2,403	24	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,403	24	47,877	75	1,494	24
25	TOTALS					\$ 8,357,495	\$ 4,673,541	\$ 260,846	25

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27 Other	Beds	2,403	24	\$	\$	75	\$	1
2	30 Depreciation	Beds	2,403	24	238,628		75	7,448	2
3	31 Amortization of Pre-Op & Org	Beds	2,403	24			75		3
4	32 Interest	Beds	2,403	24	210,931		75	6,583	4
5	33 Real Estate Taxes	Beds	2,403	24			75		5
6	34 Rent-Facility & Grounds	Beds	2,403	24	159,466		75	4,977	6
7	35 Rent-Equipment & Vehicles	Beds	2,403	24	239,478		75	7,474	7
8	36 Other	Beds	2,403	24			75		8
9	38 Medically Nec Transportation	Beds	2,403	24			75		9
10	39 Ancillary Service Centers	Beds	2,403	24			75		10
11	40 Barber and Beauty Shops	Beds	2,403	24			75		11
12	41 Coffee and Gift Shops	Beds	2,403	24			75		12
13	42 Other	Beds	2,403	24			75		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				\$ 848,503	\$		\$ 26,482	25

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10										
						Name of Lender	Related**						Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES									NO	Original				Balance
	<b>A. Directly Facility Related</b>																				
	<b>Long-Term</b>																				
1	LaSalle National Bank		XX	Mortgage	\$22,274.00	01/26/01	\$ 3,017,866	\$ 2,724,115	01/31/05	variable	\$ 95,116	1									
2	Loan Amortization		XX	Mortgage							4,571	2									
3	Central Office Allocation		XX	Interest Income								3									
4									0			4									
5												5									
	<b>Working Capital</b>																				
6	Central Office Allocation		xx	Working Capital							10,191	6									
7	Central Office Allocation		xx	Working Capital							6,583	7									
8												8									
9	TOTAL Facility Related				\$22,274.00		\$ 3,017,866	\$ 2,724,115			\$ 116,461	9									
	<b>B. Non-Facility Related*</b>																				
10	Interest Income										(38)	10									
11												11									
12												12									
13												13									
14	TOTAL Non-Facility Related						\$	\$			\$ (38)	14									
15	TOTALS (line 9+line14)						\$ 3,017,866	\$ 2,724,115			\$ 116,423	15									

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

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

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

Facility Name & ID Number Heritage Manor-Mount Zion# 0044073 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2002 report.	\$	61,415	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.)	\$	61,326	2	
3.	Under or (over) accrual (line 2 minus line 1).	\$	(89)	3	
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	64,393	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.	\$	64,304	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1998	8		
		1999	9		
		2000	10		
		2001	11		
		2002	12		
				<b>FOR OHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2002	\$		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:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 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 Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor-Mount Zion COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0044073

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 2002 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 2002.

(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>121704210003</u>	<u>Heritage Manor-Mount Zion</u>	\$ <u>30,663.00</u>	\$ <u>30,663.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>30,663.00</u>	\$ <u>30,663.00</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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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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	Land			\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	3

Facility Name &amp; ID Number Heritage Manor-Mount Zion

# 0044073

Report Period Beginning:

01/01/2003

Ending: 12/31/2003

**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	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	75			\$ 1,076,000	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Environmental Site Study		1998	1,662					
10	Sign		1998	1,860					
11	Air conditioning Unit		1999	5,732					
12	Air Conditioner		1999	750					
13	Professional Fees --Remodeling Project		1999	15,922					
14									
15	Facility Remodel -- Materials		2000	241,637					
16	Professional Fees --Remodeling Project		2000	58,519					
17	Kitchen A/C		2000	990					
18	Fire Alarm		2000	1,997					
19	Door Guard System		2000	3,444					
20									
21	Smoke Detectors		2001	3,775					
22	Water Main Break		2001	3,426					
23	Commercial Disposer		2001	757					
24	Heat Pump		2001	5,158					
25	Carpet Extract		2001	1,206					
26			2001						
27	Facility Remodel -- Contractor		2001	1,397,646					
28	Professional Fees --Remodeling Project		2001	45,077					
29									
30	Facility Remodel -- Contractor		2002	2,762					
31	Fire Dampers		2002	2,766					
32									
33									
34	C/O Allocation						7,448	7,448	
35	Book Depreciation				149,776		149,776		434,464
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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Mount Zion

# 0044073

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

**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									37
38	Asphalt Sealing	2003	1,447						38
39	Sprinklers	2003	2,680						39
40	Storm Windows	2003	1,173						40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,876,386	\$ 149,776		\$ 157,224	\$ 7,448	\$ 434,464	70

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

Facility Name & ID Number Heritage Manor-Mount Zion

# 0044073

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

**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	\$ 2,876,386	\$ 149,776		\$ 157,224	\$ 7,448	\$ 434,464		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)	\$ 2,876,386	\$ 149,776		\$ 157,224	\$ 7,448	\$ 434,464		34

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

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	\$ 341,538	\$ 53,366	\$ 53,366	\$		\$ 210,527	71
72	Current Year Purchases	10,436						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 351,974	\$ 53,366	\$ 53,366	\$		\$ 210,527	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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,278,360	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 203,142	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 210,590	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,448	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 644,991	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 Date of Lease	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.	<u>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.  
 This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
 by the length of the lease \_\_\_\_\_.

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

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

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ 11,623 Description: pager, computer equipment

(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 NURSE AIDE TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED AIDES 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 AIDE _____</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 AIDE _____</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		474		474
3	Classroom Wages (a)		1,101		1,101
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	<b>TOTALS</b>	\$	\$ 1,575	\$	\$ 1,575
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,575		

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES 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 aide 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 aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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	\$		\$ 72,053	\$		\$ 72,053	1
2	Licensed Speech and Language Development Therapist		hrs			22,920			22,920	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			82,947	1,610		84,557	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				325,885		325,885	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					9,225			9,225	13
14	TOTAL			\$		\$ 187,145	\$ 327,495		\$ 514,640	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number Heritage Manor-Mount Zion

# 0044073

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(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	\$ 8,691	\$	1
2 Cash-Patient Deposits	8,845		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	285,342		3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	630		6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	(1,135,104)		8
9 Other(specify):			9
<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (831,596)	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	50,000		13
14 Buildings, at Historical Cost	2,876,387		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	351,974		16
17 Accumulated Depreciation (book methods)	(644,991)		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):	9,523		23
<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,642,893	\$	24
<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,811,297	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 105,823	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	8,845		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	111,274		30
31 Accrued Taxes Payable (excluding real estate taxes)	2,175		31
32 Accrued Real Estate Taxes(Sch.IX-B)	64,393		32
33 Accrued Interest Payable	7,667		33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 Escrow			36
37			37
<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 300,177	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable	2,724,115		40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,724,115	\$	45
<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,024,292	\$	46
47 <b>TOTAL EQUITY</b> (page 18, line 24)	\$ (1,212,995)	\$	47
<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,811,297	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(993,081)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(993,081)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(219,914)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(219,914)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,212,995)</b>	<b>24</b> *

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

Facility Name & ID Number Heritage Manor-Mount Zion

# 0044073

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

**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	\$ 2,826,937	1
2	Discounts and Allowances for all Levels	(690,411)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,136,526	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	381,949	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 381,949	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,895	12
13	Barber and Beauty Care	5,262	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	445	16
17	Sale of Drugs	262,264	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	40	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 269,906	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	38	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 38	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>	\$ 2,788,419	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	490,921	31
32	Health Care	1,352,492	32
33	General Administration	727,867	33
<b>B. Capital Expense</b>			
34	Ownership	382,022	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	5,591	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37		49,440	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,008,333	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(219,914)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (219,914)	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-Mount Zion

# 0044073

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

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	2,032	2,216	\$ 39,091	\$ 17.64	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	2,647	2,879	57,738	20.05	3
4	Licensed Practical Nurses	12,545	13,165	238,138	18.09	4
5	Nurse Aides & Orderlies	43,373	44,921	454,555	10.12	5
6	Nurse Aide Trainees	175	175	1,101	6.29	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,216	3,666	45,027	12.28	8
9	Activity Director					9
10	Activity Assistants	2,225	2,474	21,990	8.89	10
11	Social Service Workers	1,774	1,847	28,569	15.47	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,324	15,303	129,665	8.47	15
16	Dishwashers					16
17	Maintenance Workers	2,024	2,175	28,756	13.22	17
18	Housekeepers	9,828	10,613	74,932	7.06	18
19	Laundry	2,951	3,180	26,577	8.36	19
20	Administrator	2,080	2,080	54,325	26.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,588	7,276	84,622	11.63	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)	105,782	111,970	\$ 1,285,086 *	\$ 11.48	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	18,000	36
37	Medical Records Consultant	1,350	37
38	Nurse Consultant		38
39	Pharmacist Consultant	2,040	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	5,752	45
46	Other(specify)		46
47			47
48			48
49	TOTAL (lines 35 - 48)	\$ 27,142	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	Nurse Aides	0	52
53	TOTAL (lines 50 - 52)	\$	53

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	
Marge Oblinger	Admin	0	\$ 54,325	Workers' Compensation Insurance	\$ 46,458	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	14,889	Advertising: Employee Recruitment	25,834	
				FICA Taxes	98,309	Health Care Worker Background Check (Indicate # of checks performed _____)	728	
				Employee Health Insurance	65,054	Central Office Allocation	2,590	
				Employee Meals		Promotional Advertising	4,084	
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations	5,021	
				Employee Hepatitis Vaccine	204	Dues and Subscriptions	5,343	
				Employee Benefits -	6,431	License and Fees	410	
				Employee Benefits - central office	21,678			
						Less: Public Relations Expense	(5,021)	
						Non-allowable advertising	(435)	
						Yellow page advertising	(4,084)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 54,325	TOTAL (agree to Schedule V, line 22, col.8)	\$ 253,023	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 34,470	
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	
								1,050
								57
							Seminar Expense	3,094
							Non Allowable	(6,417)
							Central Office Allocation	4,215
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 1,999
C. Professional Services								
Vendor/Payee	Type		Amount					
Heritage Enterprises	Management Fees		\$ 174,396					
			0					
			0					
Legal Fees (Adjusted to zero)			10,055					
			0					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 184,451					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Heritage Manor-Mount Zion# 0044073Report Period Beginning: 01/01/2003Ending: 12/31/2003**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? No 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 Years
- (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 \_\_\_\_\_ NO No If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 41,063  
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 of Public Aid, 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? No 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. \$ 234
- (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?  
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: Pellman & Dold 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 Complete as of 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 \$2500, 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.

