

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044073

Facility Name: Heritage Manor-Mount Zion

Address: 1225 Woodland Drive Mount Zion 62549
 Number City Zip Code

County: Macon

Telephone Number: (217) 864-2356 Fax # ()

HFS ID Number: 370909086024

Date of Initial License for Current Owners: 1998

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Craig L. Ater</u>	
	(Title) <u>Senior V.P. & CFO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____	Fax # () _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number Heritage Manor-Mount Zion# 0044073 Report Period Beginning: 01/01/06 Ending: 12/31/06

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>75</u>	Skilled (SNF)	<u>75</u>	<u>27,375</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>75</u>	TOTALS	<u>75</u>	<u>27,375</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>17,758</u>	<u>3,301</u>	<u>5,261</u>	<u>26,320</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>17,758</u>	<u>3,301</u>	<u>5,261</u>	<u>26,320</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.15%

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 & 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 1998

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 5,261Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Manor-Mount Zion # 0044073 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	
	A. General Services											
1	Dietary	152,083	14,310		166,393		166,393	3,804	170,197			1
2	Food Purchase		139,114		139,114		139,114	4	139,118			2
3	Housekeeping	47,410	14,197		61,607		61,607		61,607			3
4	Laundry	57,341	9,417		66,758		66,758		66,758			4
5	Heat and Other Utilities			83,426	83,426		83,426	1,021	84,447			5
6	Maintenance	38,656	23,052	21,205	82,913		82,913	9,363	92,276			6
7	Other (specify):*											7
8	TOTAL General Services	295,490	200,090	104,631	600,211		600,211	14,192	614,403			8
	B. Health Care and Programs											
9	Medical Director			21,000	21,000		21,000	1,402	22,402			9
10	Nursing and Medical Records	950,432	83,313	41,403	1,075,148		1,075,148		1,075,148			10
10a	Therapy		233,150	458,527	691,677	(477,491)	214,186	232,314	446,500			10a
11	Activities	31,386	3,250		34,636		34,636	999	35,635			11
12	Social Services	38,297		7,560	45,857		45,857		45,857			12
13	CNA Training	2,270	786		3,056		3,056	1,331	4,387			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,022,385	320,499	528,490	1,871,374	(477,491)	1,393,883	236,046	1,629,929			16
	C. General Administration											
17	Administrative	73,329			73,329		73,329	51,886	125,215			17
18	Directors Fees							4,289	4,289			18
19	Professional Services			257,349	257,349		257,349	(246,625)	10,724			19
20	Dues, Fees, Subscriptions & Promotions			74,564	74,564	(41,063)	33,502	(14,184)	19,318			20
21	Clerical & General Office Expenses	121,858	8,016	16,756	146,630		146,630	105,303	251,933			21
22	Employee Benefits & Payroll Taxes			294,420	294,420		294,420	24,468	318,888			22
23	Inservice Training & Education			1,518	1,518		1,518	481	1,999			23
24	Travel and Seminar			7,749	7,749		7,749	(5,750)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			56,513	56,513		56,513	1,439	57,952			26
27	Other (specify):*			27,565	27,565		27,565	(27,487)	78			27
28	TOTAL General Administration	195,187	8,016	736,434	939,637	(41,063)	898,575	(106,180)	792,395			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,513,062	528,605	1,369,555	3,411,222	(518,554)	2,892,669	144,058	3,036,727			29

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

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

Facility Name & ID Number Heritage Manor-Mount Zion #0044073 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	
	D. Ownership											
30	Depreciation			176,191	176,191		176,191	8,470	184,661			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			249,809	249,809		249,809	12,072	261,881			32
33	Real Estate Taxes			55,957	55,957		55,957		55,957			33
34	Rent-Facility & Grounds							4,561	4,561			34
35	Rent-Equipment & Vehicles			2,588	2,588		2,588	1,104	3,692			35
36	Other (specify):*											36
37	TOTAL Ownership			484,545	484,545		484,545	26,207	510,752			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					477,491	477,491		477,491			39
40	Barber and Beauty Shops		43	9,841	9,884		9,884		9,884			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					41,063	41,063		41,063			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		43	9,841	9,884	518,554	528,438		528,438			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,513,062	528,648	1,863,941	3,905,651		3,905,651	170,265	4,075,916			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:

01/01/06

Ending:

12/31/06

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		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	(132)	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	(460)	20		17
18	Fines and Penalties				18
19	Entertainment	(12,825)	24		19
20	Contributions	(487)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,821)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,000)	27		24
25	Fund Raising, Advertising and Promotional	(17,801)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (70,526)		\$	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)	240,791		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 240,791		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 170,265		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Mount Zion

ID# 0044073

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(460)	20
18			18
19			24
20		(487)	27
21			21
22		(11,821)	19
23			23
24		(27,000)	27
25		(17,801)	20
26			26
27			27
28			28
29		0	33
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(57,569)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Mount Zion

0044073

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,804	0	0	0	0	0	0	0	0	3,804	1
2	Food Purchase	0	0	4	0	0	0	0	0	0	0	0	4	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,021	0	0	0	0	0	0	0	0	1,021	5
6	Maintenance	0	0	9,363	0	0	0	0	0	0	0	0	9,363	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	14,192	0	0	0	0	0	0	0	0	14,192	8
	B. Health Care and Programs													
9	Medical Director	0	0	1,402	0	0	0	0	0	0	0	0	1,402	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	232,314	0	0	0	0	0	0	0	0	0	232,314	10a
11	Activities	0	0	999	0	0	0	0	0	0	0	0	999	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA 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	TOTAL Health Care and Programs	0	232,314	3,732	0	0	0	0	0	0	0	0	236,046	16
	C. General Administration													
17	Administrative	0	0	51,886	0	0	0	0	0	0	0	0	51,886	17
18	Directors Fees	0	0	4,289	0	0	0	0	0	0	0	0	4,289	18
19	Professional Services	(11,821)	(244,070)	9,266	0	0	0	0	0	0	0	0	(246,625)	19
20	Fees, Subscriptions & Promotions	(18,261)	0	4,077	0	0	0	0	0	0	0	0	(14,184)	20
21	Clerical & General Office Expenses	0	0	105,303	0	0	0	0	0	0	0	0	105,303	21
22	Employee Benefits & Payroll Taxes	0	0	24,468	0	0	0	0	0	0	0	0	24,468	22
23	Inservice Training & Education	0	0	481	0	0	0	0	0	0	0	0	481	23
24	Travel and Seminar	(12,825)	0	7,075	0	0	0	0	0	0	0	0	(5,750)	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	1,439	0	0	0	0	0	0	0	0	1,439	26
27	Other (specify):*	(27,487)	0	0	0	0	0	0	0	0	0	0	(27,487)	27
28	TOTAL General Administration	(70,394)	(244,070)	208,284	0	0	0	0	0	0	0	0	(106,180)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(70,394)	(11,756)	226,208	0	0	0	0	0	0	0	0	144,058	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Mount Zion

0044073

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	8,470	0	0	0	0	0	0	0	8,470	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(132)	0	0	12,204	0	0	0	0	0	0	0	12,072	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	4,561	0	0	0	0	0	0	0	4,561	34
35	Rent-Equipment & Vehicles	0	0	0	1,104	0	0	0	0	0	0	0	1,104	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(132)	0	0	26,339	0	26,207	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(70,526)	(11,756)	226,208	26,339	0	170,265	45						

Facility Name & ID Number Heritage Manor-Mount Zion

0044073

Report Period Beginning:

01/01/06

Ending:

12/31/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization						2
3	V							3
4	V	19 Adjustment for Related Organization	244,070	Heritage Enterprises, Inc.			(244,070)	4
5	V							5
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		232,314	232,314	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 244,070			\$ 232,314	\$ * (11,756)	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: 01/01/06 Ending: 12/31/06

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%	\$ 3,804	\$ 3,804	15
16	V	2 Food Purchase				4	4	16
17	V	3 Housekeeping				0		17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,021	1,021	19
20	V	6 Maintenance				9,363	9,363	20
21	V	7 Other				0		21
22	V	9 Medical Director				1,402	1,402	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				999	999	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				1,331	1,331	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				51,886	51,886	29
30	V	18 Directors Fees				4,289	4,289	30
31	V	19 Professional Services				9,266	9,266	31
32	V	20 Fees, Subscription, Promotions				4,077	4,077	32
33	V	21 Clerical & General Office Expenses				105,303	105,303	33
34	V	22 Employee Benefits & Payroll Taxes				24,468	24,468	34
35	V	23 Inservice Training & Education				481	481	35
36	V	24 Travel and Seminar				7,075	7,075	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				1,439	1,439	38
39	Total		\$			\$ 226,208	\$ * 226,208	39

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

Facility Name & ID Number Heritage Manor-Mount Zion# 0044073Report Period Beginning: 01/01/06Ending: 12/31/06**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				8,470	8,470	16	
17	V	31 Amortization of Pre-Op & Org				0		17	
18	V	32 Interest				12,204	12,204	18	
19	V	33 Real Estate Taxes				0		19	
20	V	34 Rent-Facility & Grounds				4,561	4,561	20	
21	V	35 Rent-Equipment & Vehicles				1,104	1,104	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		\$			\$ 26,339	\$ *	26,339	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: 01/01/06 Ending: 12/31/06

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	Susie Jefferson	Director	Management	15.86		10	100.00	Brd Fees/salar	\$ 11,372	Line 17/18	1
2	Craig Hart	Chairman	Management	31.95		10	100.00	Brd Fees/salary	13,568	Line 17/18	2
3	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Brd Fees/salary	7,763	Line 17/18	3
4	Steve Wannemacher	President	Management	0.42		40	100.00	Brd Fees/salary	10,155	Line 17/18	4
5	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Brd Fees/salary	5,077	Line 17/18	5
6	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Brd Fees/salary	5,723	Line 17/18	6
7	Ben Hart	Vice President	Management	3.20		40	100.00	Brd Fees/salary	2,517	Line 17/18	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 56,175		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:

01/01/06

Ending: 12/31/06

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	2,624	25	\$ 133,074	\$ 132,833	75	\$ 3,804	1
2	2	Food Purchase	Beds	2,624	25	143	0	75	4	2
3	3	Housekeeping	Beds	2,624	25	0	0	75	0	3
4	4	Laundry	Beds	2,624	25	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,624	25	35,724	0	75	1,021	5
6	6	Maintenance	Beds	2,624	25	327,581	62,300	75	9,363	6
7	7	Other	Beds	2,624	25	0	0	75	0	7
8	9	Medical Director	Beds	2,624	25	49,042	0	75	1,402	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	49,042	75	0	9
10	11	Activities	Beds	2,624	25	34,967	0	75	999	10
11	12	Social Service	Beds	2,624	25	0	34,801	75	0	11
12	13	Nurse Aide Training	Beds	2,624	25	46,566	41,273	75	1,331	12
13	14	Program Transportation	Beds	2,624	25	0	0	75	0	13
14	15	Other	Beds	2,624	25	0	0	75	0	14
15	17	Administrative	Beds	2,624	25	1,815,310	1,815,310	75	51,886	15
16	18	Directors Fees	Beds	2,624	25	150,067	0	75	4,289	16
17	19	Professional Services	Beds	2,624	25	324,175	0	75	9,266	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	142,650	0	75	4,077	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,684,216	3,344,318	75	105,303	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	856,060	0	75	24,468	20
21	23	Inservice Training & Education	Beds	2,624	25	16,846	0	75	481	21
22	24	Travel and Seminar	Beds	2,624	25	247,517	0	75	7,075	22
23	25	Other Admin. Staff Transportatio	Beds	2,624	25	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,624	25	50,353	0	75	1,439	24
25	TOTALS					\$ 7,914,291	\$ 5,479,877		\$ 226,208	25

Facility Name & ID Number Heritage Manor-Mount Zion

0044073

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,624	25	\$	75	\$	1
2	30	Depreciation	Beds	2,624	25	296,327	75	8,470	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		75		3
4	32	Interest	Beds	2,624	25	426,988	75	12,204	4
5	33	Real Estate Taxes	Beds	2,624	25		75		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	159,570	75	4,561	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	38,632	75	1,104	7
8	36	Other	Beds	2,624	25		75		8
9	38	Medically Nec Transportation	Beds	2,624	25		75		9
10	39	Ancillary Service Centers	Beds	2,624	25		75		10
11	40	Barber and Beauty Shops	Beds	2,624	25		75		11
12	41	Coffee and Gift Shops	Beds	2,624	25		75		12
13	42	Other	Beds	2,624	25		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					\$ 921,517	\$	\$ 26,339	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LsSalle National Bank		xx	Mortgage	13440 + Int	4/1/2006	\$	\$ 2,932,486	4/1/2011	variable	\$ 231,962	1								
2	LsSalle National Bank		xx	Mortgage							4,254	2								
3												3								
4												4								
5												5								
Working Capital																				
6	LsSalle National Bank		xx	Working Capital						variable	13,593	6								
7	LsSalle National Bank		xx									7								
8												8								
9	TOTAL Facility Related						\$	\$ 2,932,486			\$ 249,809	9								
B. Non-Facility Related*																				
10	Interest Income										(132)	10								
11	Allocated Corporate										12,204	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 12,072	14								
15	TOTALS (line 9+line14)						\$	\$ 2,932,486			\$ 261,881	15								

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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.

2005 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 2005 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 2005.

(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>12-17-04-210-003</u>	<u>Nursing Home</u>	\$ <u>56,522.00</u>	\$ <u>56,522.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>56,522.00</u>	\$ <u>56,522.00</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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-Mount Zion

0044073 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,696 B. General Construction Type: Exterior Brick/Wood Frame Wood Number of Stories 1

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

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

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

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

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

none

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>50,000</u>	1
2					2
3	TOTALS			\$ <u>50,000</u>	3

Facility Name & ID Number Heritage Manor-Mount Zion

0044073

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	75				\$ 1,076,000	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Environmental Site Study		1998	1,662						9
10		Sign		1998	1,860						10
11		Air conditioning Unit		1999	5,732						11
12		Air Conditioner		1999	750						12
13		Professional Fees --Remodeling Project		1999	15,922						13
14											14
15		Facility Remodel -- Materials		2000	241,637						15
16		Professional Fees --Remodeling Project		2000	58,519						16
17		Kitchen A/C		2000	990						17
18		Fire Alarm		2000	1,997						18
19		Door Guard System		2000	3,444						19
20											20
21		Smoke Detectors		2001	3,775						21
22		Water Main Break		2001	3,426						22
23		Commercial Disposer		2001	757						23
24		Heat Pump		2001	5,158						24
25		Carpet Extract		2001	1,206						25
26				2001							26
27		Facility Remodel -- Contractor		2001	1,397,646						27
28		Professional Fees --Remodeling Project		2001	45,077						28
29											29
30		Facility Remodel -- Contractor		2002	2,762						30
31		Fire Dampers		2002	2,766						31
32											32
33											33
34		C/O Allocation						8,470	8,470		34
35		Book Depreciation				147,593		147,593		876,216	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-Mount Zion

0044073

Report Period Beginning:

01/01/06

Ending:

12/31/06

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		
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	Water Heater	2004	1,114					42	
43	Disposal	2004	871					43	
44								44	
45	A/C Laundry Room	2005	2,968					45	
46								46	
47	Sidewalk	2006	4,080					47	
48	Parking Lot Sealcoat	2006	2,225					48	
49	Dishroom rehab	2006	3,631					49	
50	Oxygen storage room rehab	2006	3,858					50	
51	Fire Alarm	2006	2,249					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	TOTAL (lines 4 thru 69)		\$ 2,897,382	\$ 147,593		\$ 156,063	\$ 8,470	\$ 876,216	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:

01/01/06

Ending:

12/31/06

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		\$ 2,897,382	\$ 147,593		\$ 156,063	\$ 8,470	\$ 876,216	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)	\$ 2,897,382	\$ 147,593		\$ 156,063	\$ 8,470	\$ 876,216	34

**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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 2,897,382	\$ 147,593		\$ 156,063	\$ 8,470	\$ 876,216		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)	\$ 2,897,382	\$ 147,593		\$ 156,063	\$ 8,470	\$ 876,216		34

**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: 01/01/06 Ending: 12/31/06

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	\$ 399,711	\$ 28,598	\$ 28,598	\$		\$ 336,839	71
72	Current Year Purchases	22,467						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 422,178	\$ 28,598	\$ 28,598	\$		\$ 336,839	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	3,369,560	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	176,191	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	184,661	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	8,470	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,213,055	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	TOTAL				\$ _____			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 3,692 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		786		786
3	Classroom Wages (a)		2,270		2,270
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 3,056	\$	\$ 3,056
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,056		

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Heritage Manor-Mount Zion# 0044073

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$		\$ 154,168	\$		\$ 154,168	1
2	Licensed Speech and Language Development Therapist		hrs			127,796			127,796	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			163,014	1,522		164,536	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				463,942		463,942	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					13,549			13,549	13
14	TOTAL			\$		\$ 458,527	\$ 465,464		\$ 923,991	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-Mount Zion # 0044073 Report Period Beginning: 01/01/06 Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,702	\$	1
2	Cash-Patient Deposits	11,968		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	947,142		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	666		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(752,632)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 212,846	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	2,897,383		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	422,179		16
17	Accumulated Depreciation (book methods)	(1,213,055)		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): <u>Loan Fees</u>	21,947		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,178,454	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,391,300	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 147,474	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,968		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	91,768		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,127		31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,347		32
33	Accrued Interest Payable	40,733		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 370,417	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,932,486		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deposits</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,932,486	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,302,903	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (911,603)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,391,300	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,055,007)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,055,007)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	143,404	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)	\$ 143,404	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (911,603)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Mount Zion# 0044073Report Period Beginning: 01/01/06Ending: 12/31/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,883,560	1
2	Discounts and Allowances for all Levels	(1,958,906)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,924,654	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,710,089	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,710,089	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,201	12
13	Barber and Beauty Care	10,336	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	401,603	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 414,180	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	132	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 132	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,049,055	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	600,211	31
32	Health Care	1,871,374	32
33	General Administration	939,637	33
B. Capital Expense			
34	Ownership	484,545	34
C. Ancillary Expense			
35	Special Cost Centers	9,884	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	<u>Non Nursing Home Expenses</u>		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,905,651	40
41	Income before Income Taxes (line 30 minus line 40)**	143,404	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 143,404	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:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,924	2,089	\$ 48,990	\$ 23.45	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	2,162	2,258	66,212	29.32	3
4	Licensed Practical Nurses	13,518	14,340	265,792	18.54	4
5	CNAs & Orderlies	50,169	52,987	554,132	10.46	5
6	CNA Trainees	240	240	2,270	9.46	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	590	598	15,306	25.60	8
9	Activity Director					9
10	Activity Assistants	2,810	3,058	31,386	10.26	10
11	Social Service Workers	2,124	2,200	38,297	17.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,987	16,755	152,083	9.08	15
16	Dishwashers					16
17	Maintenance Workers	1,979	2,123	38,656	18.21	17
18	Housekeepers	6,588	6,994	47,410	6.78	18
19	Laundry	6,391	6,747	57,341	8.50	19
20	Administrator	1,950	2,080	73,329	35.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,585	8,386	121,858	14.53	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)	114,017	120,855	\$ 1,513,062 *	\$ 12.52	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	21,000		36
37	Medical Records Consultant	1,080		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,250		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	7,560		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 31,890		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 1,715		50
51	Licensed Practical Nurses	2,960		51
52	Certified Nurse Assistants/Aides	31,988		52
53	TOTAL (lines 50 - 52)	\$ 36,663		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 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 _____ NO xx 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 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, 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. \$ 164
- (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? _____
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
- g. Does the facility transport residents to and from day training? _____**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Not available at this time
- (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.

Name	Title	Function	Ownership Interest	Compensation Received From Other Homes	Week Devoted to this Business and % of Total Work Week	Description	Compensation in Costs for Reporting	Schedule V Line & Column	Total Pay	Amount Paid by Mgmt	Total # Beds	Facility # Beds	Nursing Home	Nursing Home	This Facility
#REF!	Susie Jeffe	Director	0	386,481	10	0 Salary	11,372	ine 17, col 1	#REF!	417,825	417,825	19,972	397,853	11,372	
#REF!	Craig Hart	Chairman	0	461,141	10	0 Salary	13,568	ine 17, col 1	#REF!	498,540	498,540	23,831	474,709	13,568	
#REF!	Cheryl Lov	Executive	0	263,831	50	1 Salary	7,763	ine 17, col 1	#REF!	285,228	285,228	13,634	271,594	7,763	
#REF!	Steve War	President	0	345,148	50	1 Salary	10,155	ine 17, col 1	#REF!	373,139	373,139	17,836	355,303	10,155	
#REF!	Connie Ho	Sr Vice Pres	0	172,549	40	1 Salary	5,077	ine 17, col 1	#REF!	186,543	186,543	8,917	177,626	5,077	
#REF!	Craig Ater	Sr Vice Pres	0	194,513	50	1 Salary	5,723	ine 17, col 1	#REF!	210,288	210,288	10,052	200,236	5,723	
	Ben Hart	Vice Pres		85,539			2,517			92,476	92,476	4,420	88,056	2,517	
13				1,909,202		TOTAL	56,175		13	2,064,039	2,064,039		1,965,377	56,175	

* 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 homes(s) as well as the amount paid. This amount must agree to the amounts disclosed.

#REF! 0 ##### total salaries
53,658 #####

**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.

0 total mgt fees

