

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 0048074

**Facility Name:** Heritage Manor-Mt. Zion

**Address:** 1225 Woodland Drive Mt. Zion 62549  
 Number City Zip Code

**County:** Macon

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

**HFS ID Number:** 203903622001

**Date of Initial License for Current Owners:** 07/2006

**Type of Ownership:**

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

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/07 to 12/31/07 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	<u>04/15/08</u>
	(Type or Print Name) <u>Craig Ater</u>	(Date)
<b>Paid Preparer</b>	(Title) <u>Sr. VP &amp; CFO</u>	
	(Signed) _____	(Date)
<b>Paid Preparer</b>	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____	Fax # ( ) _____
	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>	

Phone # (217) 782-1630

Facility Name & ID Number Heritage Manor-Mt. Zion# 0048074 Report Period Beginning: 01/01/07 Ending: 12/31/07

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>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>16,985</u>	<u>4,602</u>	<u>4,459</u>	<u>26,046</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>16,985</u>	<u>4,602</u>	<u>4,459</u>	<u>26,046</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.15%

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)  
\_\_\_\_\_F. Does the facility maintain a daily midnight census? yes

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

YES  NO 

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

YES  NO 

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

Date started 07/2006

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

YES  Date 07/2006 NO 

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 4,459Medicare Intermediary WPS

## IV. ACCOUNTING BASIS

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

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

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

Facility Name & ID Number Heritage Manor-Mt. Zion # 0048074 Report Period Beginning: 01/01/07 Ending: 12/31/07

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	155,924	14,699		170,623		170,623	4,068	174,691			1
2	Food Purchase		147,416		147,416		147,416	16	147,432			2
3	Housekeeping	61,514	13,588		75,102		75,102		75,102			3
4	Laundry	67,431	9,258		76,689		76,689		76,689			4
5	Heat and Other Utilities			92,096	92,096		92,096	1,159	93,255			5
6	Maintenance	40,167	25,447	24,019	89,633		89,633	9,195	98,828			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>325,036</b>	<b>210,408</b>	<b>116,115</b>	<b>651,559</b>		<b>651,559</b>	<b>14,438</b>	<b>665,997</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			30,000	30,000		30,000	1,457	31,457			9
10	Nursing and Medical Records	956,753	91,494	27,979	1,076,226		1,076,226		1,076,226			10
10a	Therapy		190,727	513,026	703,753	(204,895)	498,858	168,154	667,012			10a
11	Activities	31,903	3,300		35,203		35,203	1,059	36,262			11
12	Social Services	44,781		5,999	50,780		50,780		50,780			12
13	CNA Training							1,348	1,348			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,033,437</b>	<b>285,521</b>	<b>577,004</b>	<b>1,895,962</b>	<b>(204,895)</b>	<b>1,691,067</b>	<b>172,018</b>	<b>1,863,085</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	81,114			81,114		81,114	48,255	129,369			17
18	Directors Fees							4,294	4,294			18
19	Professional Services			151,159	151,159		151,159	(143,665)	7,494			19
20	Dues, Fees, Subscriptions & Promotions			67,354	67,354	(41,063)	26,291	(5,600)	20,691			20
21	Clerical & General Office Expenses	91,377	17,642	13,445	122,464		122,464	105,938	228,402			21
22	Employee Benefits & Payroll Taxes			399,644	399,644		399,644	29,012	428,656			22
23	Inservice Training & Education			982	982		982	300	1,282			23
24	Travel and Seminar			4,694	4,694		4,694	(2,695)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,942	52,942		52,942	4,277	57,219			26
27	Other (specify):*			240	240		240	(100)	140			27
28	<b>TOTAL General Administration</b>	<b>172,491</b>	<b>17,642</b>	<b>690,460</b>	<b>880,593</b>	<b>(41,063)</b>	<b>839,530</b>	<b>40,016</b>	<b>879,546</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,530,964</b>	<b>513,571</b>	<b>1,383,579</b>	<b>3,428,114</b>	<b>(245,958)</b>	<b>3,182,156</b>	<b>226,472</b>	<b>3,408,628</b>			<b>29</b>

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

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

Facility Name & ID Number Heritage Manor-Mt. Zion #0048074 Report Period Beginning: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			178,657	178,657		178,657	7,423	186,080		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			249,190	249,190		249,190	2,718	251,908		32
33	Real Estate Taxes			60,583	60,583		60,583		60,583		33
34	Rent-Facility & Grounds							4,533	4,533		34
35	Rent-Equipment & Vehicles			4,841	4,841		4,841	1,234	6,075		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			493,271	493,271		493,271	15,908	509,179		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers					204,895	204,895		204,895		39
40	Barber and Beauty Shops		214	12,694	12,908		12,908		12,908		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>		214	12,694	12,908	245,958	258,866		258,866		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,530,964	513,785	1,889,544	3,934,293		3,934,293	242,380	4,176,673		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-Mt. Zion

# 0048074

Report Period Beginning: 01/01/07

Ending: 12/31/07

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(2,298)	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	(530)	20		17
18	Fines and Penalties				18
19	Entertainment	(9,669)	24		19
20	Contributions	(100)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,743)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(9,640)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		33		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (24,980)		\$	30

BHF 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)	267,360		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 267,360		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 242,380		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-Mt. Zion

ID# 0048074

Report Period Beginning: 01/01/07

Ending: 12/31/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(530)	20
18			18
19			24
20		(100)	27
21			21
22		(2,743)	19
23			23
24		0	27
25		(9,640)	20
26			26
27			27
28			28
29		0	33
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(13,013)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Mt. Zion

# 0048074

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	4,068	0	0	0	0	0	0	0	0	4,068	1
2	Food Purchase	0	0	16	0	0	0	0	0	0	0	0	16	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	1,159	0	0	0	0	0	0	0	0	1,159	5
6	Maintenance	0	0	9,195	0	0	0	0	0	0	0	0	9,195	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	14,438	0	0	0	0	0	0	0	0	14,438	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	1,457	0	0	0	0	0	0	0	0	1,457	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	168,154	0	0	0	0	0	0	0	0	0	168,154	10a
11	Activities	0	0	1,059	0	0	0	0	0	0	0	0	1,059	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,348	0	0	0	0	0	0	0	0	1,348	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	168,154	3,864	0	0	0	0	0	0	0	0	172,018	16
	<b>C. General Administration</b>													
17	Administrative	0	0	48,255	0	0	0	0	0	0	0	0	48,255	17
18	Directors Fees	0	0	4,294	0	0	0	0	0	0	0	0	4,294	18
19	Professional Services	(2,743)	(146,957)	6,035	0	0	0	0	0	0	0	0	(143,665)	19
20	Fees, Subscriptions & Promotions	(10,170)	0	4,570	0	0	0	0	0	0	0	0	(5,600)	20
21	Clerical & General Office Expenses	0	0	105,938	0	0	0	0	0	0	0	0	105,938	21
22	Employee Benefits & Payroll Taxes	0	0	29,012	0	0	0	0	0	0	0	0	29,012	22
23	Inservice Training & Education	0	0	300	0	0	0	0	0	0	0	0	300	23
24	Travel and Seminar	(9,669)	0	6,974	0	0	0	0	0	0	0	0	(2,695)	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	4,277	0	0	0	0	0	0	0	0	4,277	26
27	Other (specify):*	(100)	0	0	0	0	0	0	0	0	0	0	(100)	27
28	<b>TOTAL General Administration</b>	(22,682)	(146,957)	209,655	0	0	0	0	0	0	0	0	40,016	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(22,682)	21,197	227,957	0	0	0	0	0	0	0	0	226,472	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Mt. Zion

# 0048074

Report Period Beginning:

01/01/07 Ending:

12/31/07

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	7,423	0	0	0	0	0	0	0	7,423	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,298)	0	0	5,016	0	0	0	0	0	0	0	2,718	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	4,533	0	0	0	0	0	0	0	4,533	34
35	Rent-Equipment & Vehicles	0	0	0	1,234	0	0	0	0	0	0	0	1,234	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,298)</b>	<b>0</b>	<b>0</b>	<b>18,206</b>	<b>0</b>	<b>15,908</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(24,980)</b>	<b>21,197</b>	<b>227,957</b>	<b>18,206</b>	<b>0</b>	<b>242,380</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization						2
3	V							3
4	V	19 Adjustment for Related Organization	146,957	Heritage Enterprises, Inc.			(146,957)	4
5	V							5
6	V	10a Adjustment for Related Organization		GreenTree Pharmacy		168,154	168,154	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 146,957			\$ 168,154	\$ * 21,197	14

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

Facility Name & ID Number Heritage Manor-Mt. Zion# 0048074Report Period Beginning: 01/01/07Ending: 12/31/07**VII. RELATED PARTIES (continued)**

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$	4,068	15
16	V	2 Food Purchase					16	16
17	V	3 Housekeeping					0	17
18	V	4 Laundry					0	18
19	V	5 Heat & Other Utilities					1,159	19
20	V	6 Maintenance					9,195	20
21	V	7 Other					0	21
22	V	9 Medical Director					1,457	22
23	V	10 Nursing & Medical Records					0	23
24	V	11 Activities					1,059	24
25	V	12 Social Service					0	25
26	V	13 Nurse Aide Training					1,348	26
27	V	14 Program Transportation					0	27
28	V	15 Other					0	28
29	V	17 Administrative					48,255	29
30	V	18 Directors Fees					4,294	30
31	V	19 Professional Services					6,035	31
32	V	20 Fees, Subscription, Promotions					4,570	32
33	V	21 Clerical & General Office Expenses					105,938	33
34	V	22 Employee Benefits & Payroll Taxes					29,012	34
35	V	23 Inservice Training & Education					300	35
36	V	24 Travel and Seminar					6,974	36
37	V	25 Other Admin. Staff Transportation					0	37
38	V	26 Insurance-Prop.Liab.Malpract					4,277	38
39	Total		\$			\$	0	\$ * 227,957 39

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

**VII. RELATED PARTIES (continued)**

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item	4 Amount	Name of Related Organization						
15	V	27	Other	\$		100.00%	\$	0	15	
16	V	30	Depreciation					7,423	16	
17	V	31	Amortization of Pre-Op & Org						17	
18	V	32	Interest					5,016	18	
19	V	33	Real Estate Taxes					0	19	
20	V	34	Rent-Facility & Grounds					4,533	20	
21	V	35	Rent-Equipment & Vehicles					1,234	21	
22	V	36	Other					0	22	
23	V	38	Medically Nec Transportation					0	23	
24	V	39	Ancillary Service Centers					0	24	
25	V	40	Barber and Beauty Shops					0	25	
26	V	41	Coffee and Gift Shops					0	26	
27	V	42	Other					0	27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$			\$	0	\$ * 18,206	39

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

Facility Name & ID Number Heritage Manor-Mt. Zion # 0048074 Report Period Beginning: 01/01/07 Ending: 12/31/07

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc	Member		100.00					\$ 4,294	line 18	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,294		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-Mt. Zion

# 0048074

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Heritage Operations Group  
 Street Address box 3188  
 City / State / Zip Code bloomington, Il 61701  
 Phone Number ( )  
 Fax Number ( )

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,624	25	\$ 142,342	\$ 142,057	75	\$ 4,068	1
2	2	Food Purchase	Beds	2,624	25	577	0	75	16	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	40,565	0	75	1,159	5
6	6	Maintenance	Beds	2,624	25	321,709	65,509	75	9,195	6
7	7	Other	Beds	2,624	25	0	0	75	0	7
8	9	Medical Director	Beds	2,624	25	50,960	0	75	1,457	8
9	10	Nursing & Medical Records	Beds	2,624	25	0	56,488	75	0	9
10	11	Activities	Beds	2,624	25	37,038	36,931	75	1,059	10
11	12	Social Service	Beds	2,624	25	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,624	25	47,168	47,168	75	1,348	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	1,688,288	1,688,288	75	48,255	15
16	18	Directors Fees	Beds	2,624	25	150,218	0	75	4,294	16
17	19	Professional Services	Beds	2,624	25	211,148	0	75	6,035	17
18	20	Fees, Subscription, Promotions	Beds	2,624	25	159,872	0	75	4,570	18
19	21	Clerical & General Office Expense	Beds	2,624	25	3,706,408	3,356,042	75	105,938	19
20	22	Employee Benefits & Payroll Tax	Beds	2,624	25	1,015,049	0	75	29,012	20
21	23	Inservice Training & Education	Beds	2,624	25	10,511	0	75	300	21
22	24	Travel and Seminar	Beds	2,624	25	243,988	0	75	6,974	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	149,629	0	75	4,277	24
25	TOTALS					\$ 7,975,470	\$ 5,392,483		\$ 227,957	25

Facility Name & ID Number Heritage Manor-Mt. Zion

# 0048074

Report Period Beginning: 01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,624	25	\$	75	\$	1
2	30	Depreciation	Beds	2,624	25	259,703	75	7,423	2
3	31	Amortization of Pre-Op & Org	Beds	2,624	25		75		3
4	32	Interest	Beds	2,624	25	175,477	75	5,016	4
5	33	Real Estate Taxes	Beds	2,624	25		75		5
6	34	Rent-Facility & Grounds	Beds	2,624	25	158,587	75	4,533	6
7	35	Rent-Equipment & Vehicles	Beds	2,624	25	43,166	75	1,234	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					\$ 636,933	\$	\$ 18,206	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	LsSalle National Bank		xx	Mortgage			\$	\$ 2,751,600		\$ 232,909	1									
2	LsSalle National Bank		xx	Mortgage						5,932	2									
3											3									
4											4									
5											5									
<b>Working Capital</b>																				
6	LsSalle National Bank		xx	Working Capital						10,349	6									
7	LsSalle National Bank		xx								7									
8											8									
9	<b>TOTAL Facility Related</b>						\$	\$ 2,751,600		\$ 249,190	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income									(2,298)	10									
11	Allocated Corporate									5,016	11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ 2,718	14									
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 2,751,600		\$ 251,908	15									

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

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

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

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

B. Real Estate Taxes

**Important**, 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 2006 report.		\$	<b>59,347</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>58,502</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(845)</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>61,428</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>60,583</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	<b>60,891</b>	<b>8</b>	
	2003	<b>57,999</b>	<b>9</b>	
	2004	<b>64,304</b>	<b>10</b>	
	2005	<b>52,039</b>	<b>11</b>	
	2006	<b>60,583</b>	<b>12</b>	

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor-Mt. Zion COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0048074

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

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

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

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-17-04-210-003</u>	<u>nursing home</u>	\$ <u>58,502.00</u>	\$ <u>58,502.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>58,502.00</u>	\$ <u>58,502.00</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Heritage Manor-Mt. Zion

# 0048074 Report Period Beginning:

01/01/07 Ending:

12/31/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 13,696 B. General Construction Type: Exterior brick Frame wood Number of Stories 1

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

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

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

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

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

none

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name & ID Number Heritage Manor-Mt. Zion# 0048074

Report Period Beginning:

01/01/07

Ending:

12/31/07**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	75				\$ 1,076,000	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
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						7,423	7,423		34
35		Book Depreciation				149,627		149,627		1,025,843	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-Mt. Zion# 0048074

Report Period Beginning:

01/01/07

Ending:

12/31/07**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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	Dishroom rehab	2007	1,290					53	
54	Mixing Valve	2007	905					54	
55	Exterior Door	2007	260					55	
56	Storage Garage	2007	25,595					56	
57	Compressor	2007	4,846					57	
58	Water Heater	2007	6,921					58	
59	Heat/Cool Unit	2007	1,300					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)		\$ 2,938,499	\$ 149,627		\$ 157,050	\$ 7,423	\$ 1,025,843	70

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

Facility Name & ID Number Heritage Manor-Mt. Zion # 0048074 Report Period Beginning: 01/01/07 Ending: 12/31/07

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 422,178	\$ 29,030	\$ 29,030	\$		\$ 365,869	71
72	Current Year Purchases	15,779						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 437,957	\$ 29,030	\$ 29,030	\$		\$ 365,869	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)	\$	3,426,456	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	178,657	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	186,080	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	7,423	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,391,712	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Heritage Manor real Estate LLC

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>164,250</u>	<u>5</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ <u>164,250</u>			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>/2008</u>	\$ <u>164,250</u>
13.	<u>/2009</u>	\$ <u>164,250</u>
14.	<u>/2010</u>	\$ <u>164,250</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: \$ 6,075 Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

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

**D. NUMBER OF CNAs TRAINED**

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

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

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

Facility Name & ID Number Heritage Manor-Mt. Zion# 0048074

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	\$		\$ 178,496	\$		\$ 178,496	1
2	Licensed Speech and Language Development Therapist		hrs			112,070			112,070	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			207,357	935		208,292	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				189,792		189,792	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					15,103			15,103	13
14	<b>TOTAL</b>			\$		\$ 513,026	\$ 190,727		\$ 703,753	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-Mt. Zion # 0048074 Report Period Beginning: 01/01/07 Ending: 12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/07 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 20,967	\$	1
2	Cash-Patient Deposits	18,859		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	563,181		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,566		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(217,372)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 388,201	\$	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	2,938,501		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	437,958		16
17	Accumulated Depreciation (book methods)	(1,391,712)		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):	22,770		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,057,517	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,445,718	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 121,994	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,859		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,985		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,788		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,428		32
33	Accrued Interest Payable	17,912		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 347,966	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,751,600		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,751,600	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,099,566	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (653,848)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,445,718	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (911,603)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (911,603)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	257,755	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)	\$ 257,755	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (653,848)	24 *

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

Facility Name & ID Number Heritage Manor-Mt. Zion

# 0048074

Report Period Beginning: 01/01/07

Ending: 12/31/07

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,924,825	1
2	Discounts and Allowances for all Levels	(2,088,978)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,835,847	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,000,240	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,000,240	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,165	12
13	Barber and Beauty Care	13,468	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	10	16
17	Sale of Drugs	338,020	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 353,663	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,298	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,298	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>	\$ 4,192,048	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	651,559	31
32	Health Care	1,895,962	32
33	General Administration	880,593	33
<b>B. Capital Expense</b>			
34	Ownership	493,271	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	12,908	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,934,293	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	257,755	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 257,755	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-Mt. Zion

# 0048074

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,666	2,080	\$ 51,270	\$ 24.65	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	2,065	2,467	72,178	29.26	3
4	Licensed Practical Nurses	11,611	13,866	265,820	19.17	4
5	CNAs & Orderlies	39,855	47,804	512,732	10.73	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,058	2,493	54,753	21.96	8
9	Activity Director					9
10	Activity Assistants	2,353	2,914	31,903	10.95	10
11	Social Service Workers	1,797	2,266	44,781	19.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,435	15,332	155,924	10.17	15
16	Dishwashers					16
17	Maintenance Workers	1,692	2,058	40,167	19.52	17
18	Housekeepers	7,630	9,130	61,514	6.74	18
19	Laundry	5,570	6,763	67,431	9.97	19
20	Administrator	1,900	2,080	81,114	39.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,221	6,623	91,377	13.80	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)	96,853	115,876	\$ 1,530,964 *	\$ 13.21	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		30,000		36
37	Medical Records Consultant		1,520		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		5,999		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 39,769		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	919	22,975		52
53	TOTAL (lines 50 - 52)	919	\$ 22,975		53





**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES xx NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Heritage Manor Mt. Zion 44073 07/2007
- (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. \$ 667
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? \_\_\_\_\_ If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_
- g. Does the facility transport residents to and from day training? \_\_\_\_\_**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Not available at this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.



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