



Facility Name & ID Number Heritage Manor-Mt. Zion

# 0048074 Report Period Beginning: 01/01/08 Ending: 12/31/08

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>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>15,390</u>	<u>6,118</u>	<u>4,404</u>	<u>25,912</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>15,390</u>	<u>6,118</u>	<u>4,404</u>	<u>25,912</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.66%

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)  
none

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 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 4,404

Medicare 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: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	174,004	16,744		190,748		190,748	4,128	194,876			1
2	Food Purchase		165,986		165,986		165,986		165,986			2
3	Housekeeping	66,785	13,676		80,461		80,461	15	80,476			3
4	Laundry	71,820	7,299		79,119		79,119		79,119			4
5	Heat and Other Utilities			110,109	110,109		110,109	1,453	111,562			5
6	Maintenance	41,176	27,346	31,357	99,879		99,879	10,339	110,218			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>353,785</b>	<b>231,051</b>	<b>141,466</b>	<b>726,302</b>		<b>726,302</b>	<b>15,935</b>	<b>742,237</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			30,000	30,000		30,000	1,685	31,685			9
10	Nursing and Medical Records	1,110,856	108,258	74,594	1,293,708		1,293,708		1,293,708			10
10a	Therapy		215,409	490,827	706,236	(224,239)	481,997	131,148	613,145			10a
11	Activities	38,185	4,637		42,822		42,822	1,085	43,907			11
12	Social Services	45,862		6,341	52,203		52,203		52,203			12
13	CNA Training		606		606		606	858	1,464			13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>1,194,903</b>	<b>328,910</b>	<b>601,762</b>	<b>2,125,575</b>	<b>(224,239)</b>	<b>1,901,336</b>	<b>134,776</b>	<b>2,036,112</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	85,498			85,498		85,498	52,274	137,772			17
18	Directors Fees							5,568	5,568			18
19	Professional Services			175,462	175,462		175,462	(169,789)	5,673			19
20	Dues, Fees, Subscriptions & Promotions			72,391	72,391	(41,063)	31,328	(6,037)	25,291			20
21	Clerical & General Office Expenses	109,900	23,494	10,054	143,448		143,448	117,294	260,742			21
22	Employee Benefits & Payroll Taxes			344,639	344,639		344,639	23,971	368,610			22
23	Inservice Training & Education			4,365	4,365		4,365	(2,366)	1,999			23
24	Travel and Seminar			7,072	7,072		7,072	(5,073)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,851	38,851		38,851	8,334	47,185			26
27	Other (specify):*			28,276	28,276		28,276	(26,054)	2,222			27
28	<b>TOTAL General Administration</b>	<b>195,398</b>	<b>23,494</b>	<b>681,110</b>	<b>900,002</b>	<b>(41,063)</b>	<b>858,939</b>	<b>(1,878)</b>	<b>857,061</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,744,086</b>	<b>583,455</b>	<b>1,424,338</b>	<b>3,751,879</b>	<b>(265,302)</b>	<b>3,486,577</b>	<b>148,833</b>	<b>3,635,410</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: 01/01/08 Ending: 12/31/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							183,194	183,194			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,222	11,222		11,222	175,952	187,174			32
33	Real Estate Taxes							62,301	62,301			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(320,365)	8,135			34
35	Rent-Equipment & Vehicles			5,344	5,344		5,344	1,387	6,731			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			345,066	345,066		345,066	102,469	447,535			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					224,239	224,239		224,239			39
40	Barber and Beauty Shops		139	16,782	16,921		16,921		16,921			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>		139	16,782	16,921	265,302	282,223		282,223			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,744,086	583,594	1,786,186	4,113,866		4,113,866	251,302	4,365,168			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: 01/01/08

Ending: 12/31/08

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(3,537)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)	(2,878)	23		16
17	Non-Care Related Fees	(560)	20		17
18	Fines and Penalties				18
19	Entertainment	(12,579)	24		19
20	Contributions	(54)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,814)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,000)	27		24
25	Fund Raising, Advertising and Promotional	(10,524)	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>	\$ (66,946)		\$	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)	318,248		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 318,248		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 251,302		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Heritage Manor-Mt. Zion

ID# 0048074

Report Period Beginning: 01/01/08

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16		(2,878)	23
17		(560)	20
18			18
19			24
20		(54)	27
21			21
22		(10,814)	19
23			23
24		(26,000)	27
25		(10,524)	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>	(50,830)	49

## STATE OF ILLINOIS

Summary A

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

# 0048074

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	4,128	0	0	0	0	0	0	0	0	4,128	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	15	0	0	0	0	0	0	0	0	15	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,453	0	0	0	0	0	0	0	0	1,453	5
6	Maintenance	0	0	10,339	0	0	0	0	0	0	0	0	10,339	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	15,935	0	0	0	0	0	0	0	0	15,935	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	1,685	0	0	0	0	0	0	0	0	1,685	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	131,148	0	0	0	0	0	0	0	0	0	131,148	10a
11	Activities	0	0	1,085	0	0	0	0	0	0	0	0	1,085	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	858	0	0	0	0	0	0	0	0	858	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	131,148	3,628	0	0	0	0	0	0	0	0	134,776	16
	<b>C. General Administration</b>													
17	Administrative	0	0	52,274	0	0	0	0	0	0	0	0	52,274	17
18	Directors Fees	0	0	5,568	0	0	0	0	0	0	0	0	5,568	18
19	Professional Services	(10,814)	(164,648)	5,673	0	0	0	0	0	0	0	0	(169,789)	19
20	Fees, Subscriptions & Promotions	(11,084)	0	5,047	0	0	0	0	0	0	0	0	(6,037)	20
21	Clerical & General Office Expenses	0	0	117,294	0	0	0	0	0	0	0	0	117,294	21
22	Employee Benefits & Payroll Taxes	0	0	23,971	0	0	0	0	0	0	0	0	23,971	22
23	Inservice Training & Education	(2,878)	0	512	0	0	0	0	0	0	0	0	(2,366)	23
24	Travel and Seminar	(12,579)	0	7,506	0	0	0	0	0	0	0	0	(5,073)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	8,334	0	0	0	0	0	0	0	0	8,334	26
27	Other (specify):*	(26,054)	0	0	0	0	0	0	0	0	0	0	(26,054)	27
28	<b>TOTAL General Administration</b>	(63,409)	(164,648)	226,179	0	0	0	0	0	0	0	0	(1,878)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(63,409)	(33,500)	245,742	0	0	0	0	0	0	0	0	148,833	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor-Mt. Zion

# 0048074

Report Period Beginning:

01/01/08 Ending:

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	175,180	0	8,014	0	0	0	0	0	0	0	183,194	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,537)	174,666	0	4,823	0	0	0	0	0	0	0	175,952	32
33	Real Estate Taxes	0	62,301	0	0	0	0	0	0	0	0	0	62,301	33
34	Rent-Facility & Grounds	0	(328,500)	0	8,135	0	0	0	0	0	0	0	(320,365)	34
35	Rent-Equipment & Vehicles	0	0	0	1,387	0	0	0	0	0	0	0	1,387	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,537)</b>	<b>83,647</b>	<b>0</b>	<b>22,359</b>	<b>0</b>	<b>102,469</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>(66,946)</b>	<b>50,147</b>	<b>245,742</b>	<b>22,359</b>	<b>0</b>	<b>251,302</b>	<b>45</b>						

Facility Name & ID Number Heritage Manor-Mt. Zion

# 0048074

Report Period Beginning:

01/01/08

Ending:

12/31/08

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V		\$			\$	\$
2	V	10a Adjustment for Related Organization		GreenTree Pharmacy		131,148	131,148
3	V						
4	V	19 Adjustment for Related Organization	164,648	Heritage Operations Group, LLC	0.00%		(164,648)
5	V						
6	V	34 Adjustment for Related Organization	328,500	Heritage Manor Real Estate, LLC	0.00%		(328,500)
7	V	33 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		62,301	62,301
8	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		167,660	167,660
9	V	30 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		175,180	175,180
10	V	32 Adjustment for Related Organization		Heritage Manor Real Estate, LLC		7,006	7,006
11	V						
12	V						
13	V						
14	Total		\$ 493,148			\$ 543,295	\$ * 50,147

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

Facility Name &amp; ID Number

Heritage Manor-Mt. Zion

# 0048074

Report Period Beginning:

01/01/08

Ending:

12/31/08

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	0.00%	\$ 4,128	\$ 4,128	15
16	V	2 Food Purchase				0		16
17	V	3 Housekeeping				15	15	17
18	V	4 Laundry				0		18
19	V	5 Heat & Other Utilities				1,453	1,453	19
20	V	6 Maintenance				10,339	10,339	20
21	V	7 Other				0		21
22	V	9 Medical Director				1,685	1,685	22
23	V	10 Nursing & Medical Records				0		23
24	V	11 Activities				1,085	1,085	24
25	V	12 Social Service				0		25
26	V	13 Nurse Aide Training				858	858	26
27	V	14 Program Transportation				0		27
28	V	15 Other				0		28
29	V	17 Administrative				52,274	52,274	29
30	V	18 Directors Fees				5,568	5,568	30
31	V	19 Professional Services				5,673	5,673	31
32	V	20 Fees, Subscription, Promotions				5,047	5,047	32
33	V	21 Clerical & General Office Expenses				117,294	117,294	33
34	V	22 Employee Benefits & Payroll Taxes				23,971	23,971	34
35	V	23 Inservice Training & Education				512	512	35
36	V	24 Travel and Seminar				7,506	7,506	36
37	V	25 Other Admin. Staff Transportation				0		37
38	V	26 Insurance-Prop.Liab.Malpract				8,334	8,334	38
39	Total		\$			\$ 245,742	\$ * 245,742	39

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	27 Other	\$		0.00%	\$ 0			15
16	V	30 Depreciation				8,014		8,014	16
17	V	31 Amortization of Pre-Op & Org				0			17
18	V	32 Interest				4,823		4,823	18
19	V	33 Real Estate Taxes				0			19
20	V	34 Rent-Facility & Grounds				8,135		8,135	20
21	V	35 Rent-Equipment & Vehicles				1,387		1,387	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		\$			\$ 22,359	\$ *	22,359	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: 01/01/08 Ending: 12/31/08

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Heritage Enterprises Inc.	Member		100.00					\$ 5,568	18/7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 5,568		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: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Beds	2,634	25	\$ 144,981	\$ 144,706	75	\$ 4,128	1
2	2	Food Purchase	Beds	2,634	25	0	0	75	0	2
3	3	Housekeeping	Beds	2,634	25	537	537	75	15	3
4	4	Laundry	Beds	2,634	25	0	0	75	0	4
5	5	Heat & Other Utilities	Beds	2,634	25	51,027	0	75	1,453	5
6	6	Maintenance	Beds	2,634	25	363,089	68,949	75	10,339	6
7	7	Other	Beds	2,634	25	0	0	75	0	7
8	9	Medical Director	Beds	2,634	25	59,193	0	75	1,685	8
9	10	Nursing & Medical Records	Beds	2,634	25	0	59,193	75	0	9
10	11	Activities	Beds	2,634	25	38,116	37,880	75	1,085	10
11	12	Social Service	Beds	2,634	25	0	0	75	0	11
12	13	Nurse Aide Training	Beds	2,634	25	30,133	29,953	75	858	12
13	14	Program Transportation	Beds	2,634	25	0	0	75	0	13
14	15	Other	Beds	2,634	25	0	0	75	0	14
15	17	Administrative	Beds	2,634	25	1,835,880	1,835,880	75	52,274	15
16	18	Directors Fees	Beds	2,634	25	195,551	0	75	5,568	16
17	19	Professional Services	Beds	2,634	25	199,226	0	75	5,673	17
18	20	Fees, Subscription, Promotions	Beds	2,634	25	177,251	0	75	5,047	18
19	21	Clerical & General Office Expense	Beds	2,634	25	4,119,374	3,752,355	75	117,294	19
20	22	Employee Benefits & Payroll Tax	Beds	2,634	25	841,855	0	75	23,971	20
21	23	Inservice Training & Education	Beds	2,634	25	17,980	0	75	512	21
22	24	Travel and Seminar	Beds	2,634	25	263,598	0	75	7,506	22
23	25	Other Admin. Staff Transportatio	Beds	2,634	25	0	0	75	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,634	25	292,705	0	75	8,334	24
25	TOTALS					\$ 8,630,496	\$ 5,929,453		\$ 245,742	25

Facility Name & ID Number Heritage Manor-Mt. Zion

# 0048074 Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	27	Other	Beds	2,634	75	\$	\$	75	\$	1
2	30	Depreciation	Beds	2,634	75	281,453		75	8,014	2
3	31	Amortization of Pre-Op & Org	Beds	2,634	75			75		3
4	32	Interest	Beds	2,634	75	169,367		75	4,823	4
5	33	Real Estate Taxes	Beds	2,634	75			75		5
6	34	Rent-Facility & Grounds	Beds	2,634	75	285,687		75	8,135	6
7	35	Rent-Equipment & Vehicles	Beds	2,634	75	48,715		75	1,387	7
8	36	Other	Beds	2,634	75			75		8
9	38	Medically Nec Transportation	Beds	2,634	75			75		9
10	39	Ancillary Service Centers	Beds	2,634	75			75		10
11	40	Barber and Beauty Shops	Beds	2,634	75			75		11
12	41	Coffee and Gift Shops	Beds	2,634	75			75		12
13	42	Other	Beds	2,634	75			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					\$ 785,222	\$		\$ 22,359	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	Bank of America		xx	Mortgage			\$	\$ 2,570,715	03/11	variable	\$ 167,660	1								
2	Bank of America		xx	Loan Fees							7,006	2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Bank of America		xx	Accounts Receivable							11,222	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$	\$ 2,570,715			\$ 185,888	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(3,537)	10								
11	Allocated Corporate										4,823	11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 1,286	14								
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 2,570,715			\$ 187,174	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none Line #           

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

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

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ <b>62,301</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>62,301</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>62,301</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	<u>57,999</u>	<u>8</u>
	2004	<u>64,304</u>	<u>9</u>
	2005	<u>52,039</u>	<u>10</u>
	2006	<u>60,583</u>	<u>11</u>
	2007	<u>62,301</u>	<u>12</u>
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

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

FACILITY NAME Heritage Manor-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 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-17-04-210-003</u>	_____	\$ <u>62,301.00</u>	\$ <u>62,301.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>62,301.00</u>	\$ <u>62,301.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

none

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

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

# 0048074

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	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						8,014	8,014		34
35		Book Depreciation				151,067		151,067		1,176,910	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 &amp; ID Number Heritage Manor-Mt. Zion

# 0048074

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Asphalt Sealing	2003	\$ 1,447	\$		\$	\$	\$	37
38	Sprinklers	2003	2,680						38
39	Storm Windows	2003	1,173						39
40									40
41	Water Heater	2004	1,114						41
42	Disposal	2004	871						42
43									43
44	A/C Laundry Room	2005	2,968						44
45									45
46	Sidewalk	2006	4,080						46
47	Parking Lot Sealcoat	2006	2,225						47
48	Dishroom rehab	2006	3,631						48
49	Oxygen storage room rehab	2006	3,858						49
50	Fire Alarm	2006	2,249						50
51									51
52	Dishroom rehab	2007	1,290						52
53	Mixing Valve	2007	905						53
54	Exterior Door	2007	260						54
55	Storage Garage	2007	25,595						55
56	Compressor	2007	4,846						56
57	Water Heater	2007	6,921						57
58	Heat/Cool Unit	2007	1,300						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)		\$ 2,938,499	\$ 151,067		\$ 159,081	\$ 8,014	\$ 1,176,910	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,938,499	\$ 151,067		\$ 159,081	\$ 8,014	\$ 1,176,910	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)	\$ 2,938,499	\$ 151,067		\$ 159,081	\$ 8,014	\$ 1,176,910	34

\*\*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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,938,499	\$ 151,067		\$ 159,081	\$ 8,014	\$ 1,176,910	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)	\$ 2,938,499	\$ 151,067		\$ 159,081	\$ 8,014	\$ 1,176,910	34

\*\*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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 2,938,499	\$ 151,067		\$ 159,081	\$ 8,014	\$ 1,176,910		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)	\$ 2,938,499	\$ 151,067		\$ 159,081	\$ 8,014	\$ 1,176,910		34

\*\*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: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 437,957	\$ 24,113	\$ 24,113	\$		\$ 389,983	71
72	Current Year Purchases	15,422						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 453,379	\$ 24,113	\$ 24,113	\$		\$ 389,983	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)	\$ 3,441,878	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 175,180	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 183,194	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,014	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,566,893	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

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

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

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

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

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

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

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

YES  NO

16. Rental Amount for movable equipment: \$ 5,344 Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		606		606
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>	\$	\$ 606	\$	\$ 606
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	606		

**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

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01/01/08

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## XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 181,784	\$		\$ 181,784	1
2	Licensed Speech and Language Development Therapist		hrs			99,168			99,168	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			200,356	689		201,045	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				214,720		214,720	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					9,519			9,519	13
14	TOTAL			\$		\$ 490,827	\$ 215,409		\$ 706,236	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: 01/01/08 Ending: 12/31/08

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

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 5,599	\$	1
2	Cash-Patient Deposits	10,930		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	839,374		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	540		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(771,654)		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 84,789	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 84,789	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 149,173	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,930		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,372		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,685		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>IPA Tax</u>	10,350		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 298,510	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 298,510	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (213,721)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 84,789	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (581,023)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (581,023)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	367,302	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)	\$ 367,302	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)	\$ (213,721)	24 *

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

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**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	\$ 4,297,715	1
2	Discounts and Allowances for all Levels	(2,120,897)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,176,818	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,898,545	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,898,545	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	6,112	12
13	Barber and Beauty Care	16,442	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	379,610	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	104	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 402,268	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,537	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,537	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>	\$ 4,481,168	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	726,302	31
32	Health Care	2,125,575	32
33	General Administration	900,002	33
<b>B. Capital Expense</b>			
34	Ownership	345,066	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	16,921	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>	\$ 4,113,866	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	367,302	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 367,302	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,932	2,188	\$ 61,136	\$ 27.94	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	2,979	3,226	90,932	28.19	3
4	Licensed Practical Nurses	15,550	16,818	334,114	19.87	4
5	CNAs & Orderlies	46,862	49,646	576,370	11.61	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,859	2,016	48,304	23.96	8
9	Activity Director					9
10	Activity Assistants	2,981	3,206	38,185	11.91	10
11	Social Service Workers	2,049	2,261	45,862	20.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,092	16,816	174,004	10.35	15
16	Dishwashers					16
17	Maintenance Workers	1,915	2,222	41,176	18.53	17
18	Housekeepers	9,100	9,771	66,785	6.84	18
19	Laundry	4,920	5,858	71,820	12.26	19
20	Administrator	1,900	2,080	85,498	41.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,401	7,041	109,900	15.61	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)	114,540	123,149	\$ 1,744,086 *	\$ 14.16	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	6,341		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 40,111		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0		50
51	Licensed Practical Nurses	561	19,641	51
52	Certified Nurse Assistants/Aides	1,967	49,164	52
53	TOTAL (lines 50 - 52)	2,528	\$ 68,805	53

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**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Marge Oblinger	admin	0	\$ 85,498	Workers' Compensation Insurance	\$ 76,132	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	24,409	Advertising: Employee Recruitment	11,577	
				FICA Taxes	133,423	Health Care Worker Background Check		
				Employee Health Insurance	90,552	(Indicate # of checks performed )	1,210	
				Employee Meals		Patient Background Checks	5,047	
				Illinois Municipal Retirement Fund (IMRF)*			13,600	
					0		5,852	
TOTAL (agree to Schedule V, line 17, col. 1)					20,123	Dues & Subscriptions	5,057	
(List each licensed administrator separately.)			\$ 85,498		23,971	License & Fees	2,960	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount		Line #	Amount	Amount		
Heritage Operations Group	Mgt Fee	\$ 164,648			\$	Out-of-State Travel		
		0				\$		
		0						
		0				In-State Travel		
						2,921		
						130		
						Seminar Expense		
						4,021		
						(12,579)		
						Central Office		
		0				7,506		
		10,814				Entertainment Expense		
		0				( )		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 175,462				\$ 1,999	

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES x NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Heritage Manor Mt. Zion 44073 07/2006
- (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. \$ 210
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
- g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. Not available at this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Item	Code	Unit	Quantity	Price	Total	Description
1	101	kg	100	1.00	100.00	101
2	102	kg	100	1.00	100.00	102
3	103	kg	100	1.00	100.00	103
4	104	kg	100	1.00	100.00	104
5	105	kg	100	1.00	100.00	105
6	106	kg	100	1.00	100.00	106
7	107	kg	100	1.00	100.00	107
8	108	kg	100	1.00	100.00	108
9	109	kg	100	1.00	100.00	109
10	110	kg	100	1.00	100.00	110
11	111	kg	100	1.00	100.00	111
12	112	kg	100	1.00	100.00	112
13	113	kg	100	1.00	100.00	113
14	114	kg	100	1.00	100.00	114
15	115	kg	100	1.00	100.00	115
16	116	kg	100	1.00	100.00	116
17	117	kg	100	1.00	100.00	117
18	118	kg	100	1.00	100.00	118
19	119	kg	100	1.00	100.00	119
20	120	kg	100	1.00	100.00	120
21	121	kg	100	1.00	100.00	121
22	122	kg	100	1.00	100.00	122
23	123	kg	100	1.00	100.00	123
24	124	kg	100	1.00	100.00	124
25	125	kg	100	1.00	100.00	125
26	126	kg	100	1.00	100.00	126
27	127	kg	100	1.00	100.00	127
28	128	kg	100	1.00	100.00	128
29	129	kg	100	1.00	100.00	129
30	130	kg	100	1.00	100.00	130
31	131	kg	100	1.00	100.00	131
32	132	kg	100	1.00	100.00	132
33	133	kg	100	1.00	100.00	133
34	134	kg	100	1.00	100.00	134
35	135	kg	100	1.00	100.00	135
36	136	kg	100	1.00	100.00	136
37	137	kg	100	1.00	100.00	137
38	138	kg	100	1.00	100.00	138
39	139	kg	100	1.00	100.00	139
40	140	kg	100	1.00	100.00	140
41	141	kg	100	1.00	100.00	141
42	142	kg	100	1.00	100.00	142
43	143	kg	100	1.00	100.00	143
44	144	kg	100	1.00	100.00	144
45	145	kg	100	1.00	100.00	145
46	146	kg	100	1.00	100.00	146
47	147	kg	100	1.00	100.00	147
48	148	kg	100	1.00	100.00	148
49	149	kg	100	1.00	100.00	149
50	150	kg	100	1.00	100.00	150
51	151	kg	100	1.00	100.00	151
52	152	kg	100	1.00	100.00	152
53	153	kg	100	1.00	100.00	153
54	154	kg	100	1.00	100.00	154
55	155	kg	100	1.00	100.00	155
56	156	kg	100	1.00	100.00	156
57	157	kg	100	1.00	100.00	157
58	158	kg	100	1.00	100.00	158
59	159	kg	100	1.00	100.00	159
60	160	kg	100	1.00	100.00	160
61	161	kg	100	1.00	100.00	161
62	162	kg	100	1.00	100.00	162
63	163	kg	100	1.00	100.00	163
64	164	kg	100	1.00	100.00	164
65	165	kg	100	1.00	100.00	165
66	166	kg	100	1.00	100.00	166
67	167	kg	100	1.00	100.00	167
68	168	kg	100	1.00	100.00	168
69	169	kg	100	1.00	100.00	169
70	170	kg	100	1.00	100.00	170
71	171	kg	100	1.00	100.00	171
72	172	kg	100	1.00	100.00	172
73	173	kg	100	1.00	100.00	173
74	174	kg	100	1.00	100.00	174
75	175	kg	100	1.00	100.00	175
76	176	kg	100	1.00	100.00	176
77	177	kg	100	1.00	100.00	177
78	178	kg	100	1.00	100.00	178
79	179	kg	100	1.00	100.00	179
80	180	kg	100	1.00	100.00	180
81	181	kg	100	1.00	100.00	181
82	182	kg	100	1.00	100.00	182
83	183	kg	100	1.00	100.00	183
84	184	kg	100	1.00	100.00	184
85	185	kg	100	1.00	100.00	185
86	186	kg	100	1.00	100.00	186
87	187	kg	100	1.00	100.00	187
88	188	kg	100	1.00	100.00	188
89	189	kg	100	1.00	100.00	189
90	190	kg	100	1.00	100.00	190
91	191	kg	100	1.00	100.00	191
92	192	kg	100	1.00	100.00	192
93	193	kg	100	1.00	100.00	193
94	194	kg	100	1.00	100.00	194
95	195	kg	100	1.00	100.00	195
96	196	kg	100	1.00	100.00	196
97	197	kg	100	1.00	100.00	197
98	198	kg	100	1.00	100.00	198
99	199	kg	100	1.00	100.00	199
100	200	kg	100	1.00	100.00	200

