

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 48074

Facility Name: Heritage Manor Mt. Zion, LLC.

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: July 2007

Type of Ownership:

☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☐	Other
		☐	"Sub-S" Corp.		
		☒	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater Telephone Number: (309) 823-7135
Email Address: cater@heritageofcare.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) Craig Ater	
Paid Preparer	(Title) Exec VP & CFO	
	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) _____	Fax # () _____
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

Facility Name & ID Number Heritage Manor Mt. Zion, LLC.

48074 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	73	Skilled (SNF)	73	26,645	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	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	16,998	4,570	3,990	25,558	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,998	4,570	3,990	25,558	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.92%

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 July 2007

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date July 2007 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified _____ and days of care provided 3,990

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCURAL ☒ 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.

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	183,138	19,172		202,310		202,310	4,096	206,406			1
2	Food Purchase		192,719		192,719		192,719	14	192,733			2
3	Housekeeping	80,639	19,919		100,558		100,558	6	100,564			3
4	Laundry	72,352	6,734		79,086		79,086	4	79,090			4
5	Heat and Other Utilities			127,544	127,544		127,544	1,443	128,987			5
6	Maintenance	35,609	38,629	35,488	109,726		109,726	10,617	120,343			6
7	Other (specify):*											7
8	TOTAL General Services	371,738	277,173	163,032	811,943		811,943	16,180	828,123			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600	59	21,659			9
10	Nursing and Medical Records	1,243,741	148,450	8,271	1,400,462		1,400,462		1,400,462			10
10a	Therapy		274,891	520,864	795,755	(288,332)	507,423	61,726	569,149			10a
11	Activities	45,714	2,501		48,215		48,215		48,215			11
12	Social Services	49,996		5,177	55,173		55,173		55,173			12
13	CNA Training							587	587			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,339,451	425,842	555,912	2,321,205	(288,332)	2,032,873	62,372	2,095,245			16
	C. General Administration											
17	Administrative	81,826			81,826		81,826	62,324	144,150			17
18	Directors Fees											18
19	Professional Services			205,332	205,332		205,332	(197,882)	7,450			19
20	Dues, Fees, Subscriptions & Promotions			90,212	90,212	(39,968)	50,244	(29,830)	20,414			20
21	Clerical & General Office Expenses	130,496	17,874	5,456	153,826		153,826	137,512	291,338			21
22	Employee Benefits & Payroll Taxes			381,823	381,823		381,823	28,914	410,737			22
23	Inservice Training & Education			629	629		629	359	988			23
24	Travel and Seminar			6,421	6,421		6,421	(4,422)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,995	36,995		36,995	8,473	45,468			26
27	Other (specify):*			840	840		840	(240)	600			27
28	TOTAL General Administration	212,322	17,874	727,708	957,904	(39,968)	917,936	5,208	923,144			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,923,511	720,889	1,446,652	4,091,052	(328,300)	3,762,752	83,760	3,846,512			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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	
	D. Ownership											
30	Depreciation							216,936	216,936			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,309	7,309		7,309	109,859	117,168			32
33	Real Estate Taxes							61,535	61,535			33
34	Rent-Facility & Grounds			328,500	328,500		328,500	(327,804)	696			34
35	Rent-Equipment & Vehicles			5,412	5,412		5,412	680	6,092			35
36	Other (specify):*											36
37	TOTAL Ownership			341,221	341,221		341,221	61,206	402,427			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					288,332	288,332		288,332			39
40	Barber and Beauty Shops			14,940	14,940		14,940		14,940			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					39,968	39,968		39,968			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			14,940	14,940	328,300	343,240		343,240			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,923,511	720,889	1,802,813	4,447,213		4,447,213	144,966	4,592,179			45

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(4,494)	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)		23		16
17	Non-Care Related Fees	(937)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,349)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,615)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(240)	27		24
25	Fund Raising, Advertising and Promotional	(32,930)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (52,565)		\$	30

BHF USE ONLY							
48		49		50		51	

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 Amount	2 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)	197,531		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 197,531		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 144,966		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 Yes	2 No	3 Amount	4 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	TOTAL (C): (sum of lines 38-46)			\$		47

ID#48074

Report Period Beginning:01/01/11

Ending:12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(937)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(2,615)	19	22
23				23
24		(240)	27	24
25		(32,930)	20	25
26				26
27				27
28				28
29			33	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(36,722)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor Mt. Zion, LLC. # 48074 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	4,096	0	0	0	0	0	0	0	0	4,096	1
2	Food Purchase	0	0	14	0	0	0	0	0	0	0	0	14	2
3	Housekeeping	0	0	6	0	0	0	0	0	0	0	0	6	3
4	Laundry	0	0	4	0	0	0	0	0	0	0	0	4	4
5	Heat and Other Utilities	0	0	1,443	0	0	0	0	0	0	0	0	1,443	5
6	Maintenance	0	0	10,617	0	0	0	0	0	0	0	0	10,617	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	16,180	0	0	0	0	0	0	0	0	16,180	8
	B. Health Care and Programs													
9	Medical Director	0	0	59	0	0	0	0	0	0	0	0	59	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	61,726	0	0	0	0	0	0	0	0	0	61,726	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	587	0	0	0	0	0	0	0	0	587	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	61,726	646	0	0	0	0	0	0	0	0	62,372	16
	C. General Administration													
17	Administrative	0	0	62,324	0	0	0	0	0	0	0	0	62,324	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,615)	(202,717)	7,450	0	0	0	0	0	0	0	0	(197,882)	19
20	Fees, Subscriptions & Promotions	(33,867)	0	4,037	0	0	0	0	0	0	0	0	(29,830)	20
21	Clerical & General Office Expenses	0	0	137,512	0	0	0	0	0	0	0	0	137,512	21
22	Employee Benefits & Payroll Taxes	0	0	28,914	0	0	0	0	0	0	0	0	28,914	22
23	Inservice Training & Education	0	0	359	0	0	0	0	0	0	0	0	359	23
24	Travel and Seminar	(11,349)	0	6,927	0	0	0	0	0	0	0	0	(4,422)	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	8,473	0	0	0	0	0	0	0	0	8,473	26
27	Other (specify):*	(240)	0	0	0	0	0	0	0	0	0	0	(240)	27
28	TOTAL General Administration	(48,071)	(202,717)	255,996	0	0	0	0	0	0	0	0	5,208	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(48,071)	(140,991)	272,822	0	0	0	0	0	0	0	0	83,760	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Manor Mt. Zion, LLC. # 48074 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	208,335	0	8,601	0	0	0	0	0	0	0	216,936	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,494)	113,912	0	441	0	0	0	0	0	0	0	109,859	32
33	Real Estate Taxes	0	61,535	0	0	0	0	0	0	0	0	0	61,535	33
34	Rent-Facility & Grounds	0	(328,500)	0	696	0	0	0	0	0	0	0	(327,804)	34
35	Rent-Equipment & Vehicles	0	0	0	680	0	0	0	0	0	0	0	680	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(4,494)	55,282	0	10,418	0	0	0	0	0	0	0	61,206	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(52,565)	(85,709)	272,822	10,418	0	0	0	0	0	0	0	144,966	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Heritage Enterprises, Inc.	100	See Page 25				

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		GreenTree Pharmacy	0.00%	61,726	61,726	2
3	V								3
4	V	19	Adjustment for Related Organization	202,717	Heritage Operations Group, LLC	0.00%		(202,717)	4
5	V								5
6	V	34	Adjustment for Related Organization	328,500	Heritage Manor Real Estate, LLC	0.00%		(328,500)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		61,535	61,535	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		108,183	108,183	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		208,335	208,335	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		5,729	5,729	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 531,217			\$ 445,508	\$ * (85,709)	14

* 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	1	Dietary	\$	Heritage Enterprises, Inc.		\$	4,096	15
16	V	2	Food Purchase					14	16
17	V	3	Housekeeping					6	17
18	V	4	Laundry					4	18
19	V	5	Heat & Other Utilities					1,443	19
20	V	6	Maintenance					10,617	20
21	V	7	Other					0	21
22	V	9	Medical Director					59	22
23	V	10	Nursing & Medical Records					0	23
24	V	11	Activities					0	24
25	V	12	Social Service					0	25
26	V	13	Nurse Aide Training					587	26
27	V	14	Program Transportation					0	27
28	V	15	Other					0	28
29	V	17	Administrative					62,324	29
30	V	18	Directors Fees					0	30
31	V	19	Professional Services					7,450	31
32	V	20	Fees, Subscription, Promotions					4,037	32
33	V	21	Clerical & General Office Expenses					137,512	33
34	V	22	Employee Benefits & Payroll Taxes					28,914	34
35	V	23	Inservice Training & Education					359	35
36	V	24	Travel and Seminar					6,927	36
37	V	25	Other Admin. Staff Transportation					0	37
38	V	26	Insurance-Prop.Liab.Malpract					8,473	38
39	Total			\$			\$	0	\$ * 272,822 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	\$	Heritage Enterprises, Inc.		\$	0	15
16	V	30	Depreciation					8,601	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					441	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					696	20
21	V	35	Rent-Equipment & Vehicles					680	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	\$ * 10,418 39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

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					\$ 0		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	\$		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, LLC. # 48074 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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	2,735	26	\$ 153,442	\$ 153,115	73	\$ 4,096	1
2	2	Food Purchase	Beds	2,735	26	520	0	73	14	2
3	3	Housekeeping	Beds	2,735	26	215	0	73	6	3
4	4	Laundry	Beds	2,735	26	151	0	73	4	4
5	5	Heat & Other Utilities	Beds	2,735	26	54,054	0	73	1,443	5
6	6	Maintenance	Beds	2,735	26	397,756	75,127	73	10,617	6
7	7	Other	Beds	2,735	26	0	0	73	0	7
8	9	Medical Director	Beds	2,735	26	2,206	0	73	59	8
9	10	Nursing & Medical Records	Beds	2,735	26	0	0	73	0	9
10	11	Activities	Beds	2,735	26	0	0	73	0	10
11	12	Social Service	Beds	2,735	26	0	0	73	0	11
12	13	Nurse Aide Training	Beds	2,735	26	22,009	20,793	73	587	12
13	14	Program Transportation	Beds	2,735	26	0	0	73	0	13
14	15	Other	Beds	2,735	26	0	0	73	0	14
15	17	Administrative	Beds	2,735	26	2,335,023	2,335,023	73	62,324	15
16	18	Directors Fees	Beds	2,735	26	0	0	73	0	16
17	19	Professional Services	Beds	2,735	26	279,109	0	73	7,450	17
18	20	Fees, Subscription, Promotions	Beds	2,735	26	151,258	0	73	4,037	18
19	21	Clerical & General Office Expenses	Beds	2,735	26	5,151,979	4,517,846	73	137,512	19
20	22	Employee Benefits & Payroll Taxes	Beds	2,735	26	1,083,278	0	73	28,914	20
21	23	Inservice Training & Education	Beds	2,735	26	13,460	0	73	359	21
22	24	Travel and Seminar	Beds	2,735	26	259,533	0	73	6,927	22
23	25	Other Admin. Staff Transportation	Beds	2,735	26	0	0	73	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,735	26	317,454	0	73	8,473	24
25	TOTALS					\$ 10,221,447	\$ 7,101,904		\$ 272,822	25

Facility Name & ID Number Heritage Manor Mt. Zion, LLC. # 48074 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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	2,735	26	\$		73	\$	1
2	30	Depreciation	Beds	2,735	26	322,258		73	8,601	2
3	31	Amortization of Pre-Op & Org	Beds	2,735	26			73		3
4	32	Interest	Beds	2,735	26	16,517		73	441	4
5	33	Real Estate Taxes	Beds	2,735	26			73		5
6	34	Rent-Facility & Grounds	Beds	2,735	26	26,080		73	696	6
7	35	Rent-Equipment & Vehicles	Beds	2,735	26	25,461		73	680	7
8	36	Other	Beds	2,735	26			73		8
9	38	Medically Nec Transportation	Beds	2,735	26			73		9
10	39	Ancillary Service Centers	Beds	2,735	26			73		10
11	40	Barber and Beauty Shops	Beds	2,735	26			73		11
12	41	Coffee and Gift Shops	Beds	2,735	26			73		12
13	42	Other	Beds	2,735	26			73		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					\$ 390,316	\$		\$ 10,418	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE												
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)												
	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		xx	Mortgage			\$	2,036,700	03/2016	variable	\$ 108,183	1
2	Bank of America		xx	Loan Fees							5,729	2
3												3
4												4
5												5
	Working Capital											
6	Bank of America		xx	Accounts Receivable							7,309	6
7												7
8												8
9	TOTAL Facility Related						\$	2,036,700			\$ 121,221	9
	B. Non-Facility Related*											
10	Interest Income										(4,494)	10
11	Allocated Corporate										441	11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (4,053)	14
15	TOTALS (line 9+line14)						\$	2,036,700			\$ 117,168	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$61,535	2
3. Under or (over) accrual (line 2 minus line 1).			\$61,535	3
4. Real Estate Tax accrual used for 2011 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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	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. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$61,535	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2006	52,039	8	
	2007	60,583	9	
	2008	62,301	10	
	2009	64,975	11	
	2010	61,535	12	
				FOR BHF USE ONLY
				13 FROM R. E. TAX STATEMENT FOR 2010 \$ 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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor Mt. Zion, LLC. COUNTY Macon

FACILITY IDPH LICENSE NUMBER 48074

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 2010 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 2010.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>121704210003</u>	<u>nursing home</u>	\$ <u>61,535.00</u>	\$ <u>61,535.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>61,535.00</u></u>	\$ <u><u>61,535.00</u></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 and 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to providecopies 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 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				\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	73				\$ 1,076,000	\$		\$		\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Environmental Site Study			1998	1,662						9
10	Sign			1998	1,860						10
11	Air conditioning Unit			1999	5,732						11
12	Air Conditioner			1999	750						12
13	Professional Fees --Remodeling Project			1999	15,922						13
14											14
15	Facility Remodel -- Materials			2000	241,637						15
16	Professional Fees --Remodeling Project			2000	58,519						16
17	Kitchen A/C			2000	990						17
18	Fire Alarm			2000	1,997						18
19	Door Guard System			2000	3,444						19
20											20
21	Smoke Detectors			2001	3,775						21
22	Water Main Break			2001	3,426						22
23	Commercial Disposer			2001	757						23
24	Heat Pump			2001	5,158						24
25	Carpet Extract			2001	1,206						25
26				2001							26
27	Facility Remodel -- Contractor			2001	1,397,646						27
28	Professional Fees --Remodeling Project			2001	45,077						28
29											29
30	Facility Remodel -- Contractor			2002	2,762						30
31	Fire Dampers			2002	2,766						31
32											32
33	C/O Allocation							8,601	8,601		33
34	Book Depreciation					172,170		172,170			34
35											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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	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									52
53									53
54									54
55	Storage Garage	2007	23,848						55
56	Compressor	2007	4,846						56
57	Water Heater	2007	6,921						57
58									58
59									59
60	Window Replacement	2009	56,034						60
61	HVAC	2009	2,656						61
62	HVAC rooftop	2009	9,250						62
63	Water Heater	2009	7,925						63
64	Parking Lot Sealcoat	2009	31,071						64
65									65
66	Water Heater	2010	16,232						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,056,165	\$ 172,170		\$ 180,771	\$ 8,601	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,056,165	\$ 172,170		\$ 180,771	\$ 8,601	\$	1
2									2
3	Nurse Call & technology system	2011	184,918						3
4	Carpet	2011	9,016						4
5	Medcare lift	2011	8,334						5
6	Asbestos Abatement	2011	11,601						6
7	Heat Exchange	2011	5,637						7
8	Air Handler Unit	2011	4,714						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)		\$ 3,280,385	\$ 172,170		\$ 180,771	\$ 8,601	\$	34

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Totals from Page 12B, Carried Forward		\$ 3,280,385	\$ 172,170		\$ 180,771	\$ 8,601	\$	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)		\$ 3,280,385	\$ 172,170		\$ 180,771	\$ 8,601	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$610,667	\$36,165	\$36,165	\$		\$	71
72	Current Year Purchases	58,892						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$669,559	\$36,165	\$36,165	\$		\$	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets			1	2
		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,999,944	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$208,335	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$216,936	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$8,601	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

**

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: \$5,412
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year EndingAnnual Rent
12. /2012\$
13. /2013\$
14. /2014\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER CNA

☐
☐
☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER CNA

☐
☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED	
COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (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.

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

	1	2	3	4	5	6	7	8		
	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	\$		\$ 173,925			\$ 173,925	1
2	Licensed Speech and Language Development Therapist		hrs			112,057			112,057	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			219,806	1,635		221,441	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				273,256		273,256	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					15,076			15,076	13
14	TOTAL			\$		\$ 520,864	\$ 274,891		\$ 795,755	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$13,436	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	906,307		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,958		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(461,651)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$462,050	\$	10
	B. Long-Term Assets			
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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$462,050	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$164,555	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	173,106		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,070)		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
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$336,591	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$336,591	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$125,459	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$462,050	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (347,895)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (347,895)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	473,354	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)	\$ 473,354	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 125,459	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,602,363	1
2	Discounts and Allowances for all Levels	(1,880,931)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,721,432	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,695,228	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,695,228	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	538	12
13	Barber and Beauty Care	14,037	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	484,838	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 499,413	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,494	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,494	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,920,567	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	811,943	31
32	Health Care	2,321,205	32
33	General Administration	957,904	33
	B. Capital Expense		
34	Ownership	341,221	34
	C. Ancillary Expense		
35	Special Cost Centers	14,940	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,447,213	40
41	Income before Income Taxes (line 30 minus line 40)**	473,354	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 473,354	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.

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	1,792	1,876	\$56,670	\$30.21	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	10,883	11,067	288,257	26.05	3
4	Licensed Practical Nurses	11,199	11,487	255,570	22.25	4
5	CNAs & Orderlies	47,985	49,102	597,568	12.17	5
6	CNA Trainees			0		6
7	Licensed Therapist	1,603	1,695		0.00	7
8	Rehab/Therapy Aides			45,676		8
9	Activity Director	3,323	3,473		0.00	9
10	Activity Assistants	2,030	2,158	45,714	21.18	10
11	Social Service Workers			49,996		11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,209	16,585	183,138	11.04	15
16	Dishwashers					16
17	Maintenance Workers	1,858	2,001	35,609	17.80	17
18	Housekeepers	7,281	7,682	80,639	10.50	18
19	Laundry	5,665	5,892	72,352	12.28	19
20	Administrator	1,900	2,080	81,826	39.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,632	7,079	130,496	18.43	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)	118,360	122,177	\$1,923,511 *	\$15.74	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$0		35
36	Medical Director		21,600		36
37	Medical Records Consultant		1,305		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,500		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		5,177		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$32,582		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	0	0		52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Stephany Taylor			\$ 81,826
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,826
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Heritage Operations Group	Mgt		\$ 202,717
			0
			0
Legal adj to Zero			2,615
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 205,332
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 57,517
Unemployment Compensation Insurance			20,785
FICA Taxes			147,149
Employee Health Insurance			145,504
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
			0
Other Benefits			10,868
Central Office Allocation			28,914
TOTAL (agree to Schedule V, line 22, col.8)			\$ 410,737
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 0
Advertising: Employee Recruitment			2,796
Health Care Worker Background Check (Indicate # of checks performed)			1,728
Patient Background Checks			
			13,388
Dues & Subscriptions			5,792
License & Fees			6,998
Central Office Allocation			4,037
Less: Public Relations Expense			(13,388)
Non-allowable advertising			(937)
Yellow page advertising			()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 20,414
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
			4,519
			105
Seminar Expense			1,797
Central Office			(4,422)
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 1,999

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 Health Care 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 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$5,000

Line

10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

no

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

YES

x

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESxx

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.

\$39,968

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 benefit on Schedule V.

\$0

Has any meal income been offset against related costs?

yes

Indicate the amount.

\$260

(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

(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
- HFS 3745 (N-4-99)

IL478-2471

FACILITY		STATE
Owned SNFs		LICENSE NUMBER
Heritage Health - South, LLC		48843
Heritage Health - Bloomington, LLC		48157
Heritage Health - Carlinville, LLC		48850
Heritage Health - Chillicothe, LLC		48868
Heritage Health - Dwight, LLC		50492
Heritage Health - Elgin, LLC		48132
Heritage Health - El Paso, LLC		48124
Heritage Health - Gibson City, LLC		48116
Heritage Health - Gillespie, LLC		48892
Heritage Health - LaSalle, LLC		51276
Heritage Health - Litchfield, LLC		48900
Heritage Health - Mendota, LLC		48108
Heritage Health - Minonk, LLC		48058
Heritage Health - Mt. Sterling, LLC		48041
Heritage Health - Mt. Zion, LLC		48074
Heritage Health - Normal, LLC		48082
Heritage Health - Pana, LLC		48884
Heritage Health - Peru, LLC		48090
Heritage Health - Staunton, LLC		48876
Heritage Health - Streator, LLC		48066
Barton W. Stone Jacksonville, LLC		48918
Danville Joint Ventures, LLC d/b/aColonial Manor		42168
Heritage Health - Springfield		41699
Cotillion Ridge		45138
Country Health		7880
Mason City Area NH		34256
St. Clara's Manor		50724
Vonderlieth Living Center		19976