

Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	69	Skilled (SNF)	69	25,254	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	69	TOTALS	69	25,254	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				
		Public Aid Recipient	Private Pay	Other		Total
8	SNF		495	5,672	6,167	8
9	SNF/PED					9
10	ICF	5,889	9,151	993	16,033	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,889	9,646	6,665	22,200	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 87.91%)

D. How many bed-hold days during this year were paid by Public Aid? 13 (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 4 / 01 / 89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04 / 01 / 86 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 20 and days of care provided 4989

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/00 Fiscal Year: 12/31/00

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

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/00 Ending: 12/31/00
 V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	102,348	7,996	4,463	114,807	791	115,598	0	115,598		1
2	Food Purchase		97,988		97,988		97,988	(517)	97,471		2
3	Housekeeping	39,683	8,274	530	48,487		48,487	0	48,487		3
4	Laundry	27,124	6,209	55	33,388		33,388	0	33,388		4
5	Heat and Other Utilities			86,416	86,416	3,627	90,043	0	90,043		5
6	Maintenance	27,781	7,346	17,167	52,294		52,294	0	52,294		6
7	Other (specify):*			510	510		510	0	510		7
8	TOTAL General Services	196,936	127,813	109,141	433,890	4,418	438,308	(517)	437,791		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000	0	6,000		9
10	Nursing and Medical Records	680,457	58,586	29,511	768,554	14,333	782,887	0	782,887		10
10a	Therapy	145,317	1,916	11,239	158,472		158,472	0	158,472		10a
11	Activities	26,630	2,113	82	28,825		28,825	0	28,825		11
12	Social Services	60,124	348		60,472		60,472	0	60,472		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Progra	912,528	62,963	46,832	1,022,323	14,333	1,036,656		1,036,656		16
	C. General Administration										
17	Administrative	70,312		158,485	228,797	(30,791)	198,006	0	198,006		17
18	Directors Fees							0			18
19	Professional Services			4,353	4,353	(3,110)	1,243	(1,243)			19
20	Dues, Fees, Subscriptions & Promotions			31,817	31,817		31,817	(24,921)	6,896		20
21	Clerical & General Office Expense	70,624	25,681	(130,197)	(33,892)	3,110	(30,782)	138,377	107,595		21
22	Employee Benefits & Payroll Taxes			263,472	263,472	(7,585)	255,887	0	255,887		22
23	Inservice Training & Education			1,301	1,301		1,301	0	1,301		23
24	Travel and Seminar			27,344	27,344		27,344	0	27,344		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			24,299	24,299		24,299	0	24,299		26
27	Other (specify):*							0			27
28	TOTAL General Administration	140,936	25,681	380,874	547,491	(38,376)	509,115	112,213	621,328		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,250,400	216,457	536,847	2,003,704	(19,625)	1,984,079	111,696	2,095,775		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.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Heartland Health Care Center-Galesbu # 0041806 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			123,257	123,257	19,625	142,882	0	142,882		30
31	Amortization of Pre-Op. & Org.			8,225	8,225		8,225	0	8,225		31
32	Interest			63,960	63,960		63,960	0	63,960		32
33	Real Estate Taxes			42,064	42,064		42,064	(1,488)	40,576		33
34	Rent-Facility & Grounds							0			34
35	Rent-Equipment & Vehicles			5,916	5,916		5,916	0	5,916		35
36	Other (specify):*							0			36
37	TOTAL Ownership			243,422	243,422	19,625	263,047	(1,488)	261,559		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		214,283	14,046	228,329		228,329	0	228,329		39
40	Barber and Beauty Shops		59	6,307	6,366		6,366	0	6,366		40
41	Coffee and Gift Shops	14,467			14,467		14,467	0	14,467		41
42	Provider Participation Fee			37,882	37,882		37,882	0	37,882		42
43	Other (specify):* IV Therapy		15,001		15,001		15,001	0	15,001		43
44	TOTAL Special Cost Centers	14,467	229,343	58,235	302,045		302,045		302,045		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,264,867	445,800	838,504	2,549,171	0	2,549,171	110,208	2,659,379		45

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

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number **Heartland Health Care Center-Galesburg**

0041806

Report Period Beginning: **01/01/00**

Ending: **12/31/00**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Program:				3
4 Non-Patient Meals	(517)	2		4
5 Telephone, TV & Radio in Resident Rooms	(36)	21		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(1,909)	21		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)	(2,690)	21		16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers	(1,243)	19		22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	146,960	21		24
25 Fund Raising, Advertising and Promotional	(24,921)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax	(1,488)	33		26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(3,948)	21		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ 110,208		\$	30

OHF 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	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)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS)			
37 TOTAL ADJUSTMENTS (A) and (B)	\$ 110,208		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		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Print Previe

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb Heartland Health Care Center-Galesburg

0041806 Report Period Beginning:

01/01/00

Ending: 12/31/00

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

Print Summary		Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
		A. General Services												
1		Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2		Food Purchase	(517)	0	0	0	0	0	0	0	0	0	0	(517) 2
3		Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4		Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5		Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6		Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7		Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8		TOTAL General Services	(517)	0	0	0	0	0	0	0	0	0	0	(517) 8
		B. Health Care and Programs												
9		Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10		Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a		Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11		Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12		Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13		Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 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 Program	0	0	0	0	0	0	0	0	0	0	0	0 16
		C. General Administration												
17		Administrative	0	0	0	0	0	0	0	0	0	0	0	0 17
18		Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19		Professional Services	(1,243)	0	0	0	0	0	0	0	0	0	0	(1,243) 19
20		Fees, Subscriptions & Promotions	(24,921)	0	0	0	0	0	0	0	0	0	0	(24,921) 20
21		Clerical & General Office Expenses	138,377	0	0	0	0	0	0	0	0	0	0	138,377 21
22		Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23		Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24		Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0 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	0	0	0	0	0	0	0	0	0	0 26
27		Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28		TOTAL General Administration	112,213	0	0	0	0	0	0	0	0	0	0	112,213 28
29		TOTAL Operating Expense (sum of lines 8,16 & 28)	111,696	0	0	0	0	0	0	0	0	0	0	111,696 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Numb Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/00

Ending:

12/31/00

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

Print Summary

Capital Expense		PAGES	PAGE	SUMMARY										
D. Ownership		5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(1,488)	0	0	0	0	0	0	0	0	0	0	(1,488)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,488)	0	(1,488)	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 Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	110,208	0	110,208	45									

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Entity Name & ID Number: Heartland Health Care Center-Calendar Year: 2014 Report Period Beginning: 01/01/00 Ending: 12/31/00 Page 6

VI. RELATED PARTIES (Show Pgs 6A thru 6) (Show Pgs 6A thru 6) (Hide Pgs 6A thru 6)

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

OWNERS				RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business		
Mount Zion, Inc.	100	Health Care & Retirement Corporation	Yuba, CA					
		SEE FILE CAPRI BENEFIT						

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.

Schedule	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustment to Related Organization Case C Column E
1	V	Supplies	100,000	HCR Mount Zion, Inc.	100.00%	100,000	
2	V	Supplies					
3	V	Supplies					
4	V	Supplies					
5	V	Supplies					
6	V	Supplies					
7	V	Supplies					
8	V	Supplies					
9	V	Supplies					
10	V	Therapy Management	9,800	Heartland Management Services	100.00%	9,800	
11	V	Therapy Management					
12	V	Therapy Management					
13	V	Therapy Management					
14	V	Therapy Management					
15	V	Therapy Management					
16	V	Therapy Management					
17	V	Therapy Management					
18	V	Therapy Management					
19	V	Therapy Management					
20	V	Therapy Management					
21	V	Therapy Management					
22	V	Therapy Management					
23	V	Therapy Management					
24	V	Therapy Management					
25	V	Therapy Management					
26	V	Therapy Management					
27	V	Therapy Management					
28	V	Therapy Management					
29	V	Therapy Management					
30	V	Therapy Management					
31	V	Therapy Management					
32	V	Therapy Management					
33	V	Therapy Management					
34	V	Therapy Management					
35	V	Therapy Management					
36	V	Therapy Management					
37	V	Therapy Management					
38	V	Therapy Management					
39	V	Therapy Management					
40	V	Therapy Management					
41	V	Therapy Management					
42	V	Therapy Management					
43	V	Therapy Management					
44	Total		109,800			109,800	

Sum 6

Total must agree with the amount revealed on line 36 of Schedule V. DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6i, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6i, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6i, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Preview

Line 1 2 3 4 5 6 7 9 10 10a 11 12 13 14 15 17 18 19 20 21 22 23 24 25 26 27 30 31 32 33 34 35 36 38 39 40 41 42 43

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.

Line #	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	N/A								\$	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 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 REI

** 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

Print Previe

| the name(s)
PORTS.

Facility Name & ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/00 Ending: 12/31/00

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 HCR ManorCare, Inc.
 Street Address 333 North Summit St.
 City / State / Zip Code Toledo, OH 43604
 Phone Number (419) 252-5500
 Fax Number (877) 329-7731

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- Direct	Accumulated Cost	#####	357 Nurs. Fac.	\$	2,436,211	\$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	#####	357 Nurs. Fac.	671,002	407,536	2,436,211	791
3	5	Utilities - Direct	Accumulated Cost	#####	357 Nurs. Fac.	262,823		2,436,211	353
4	5	Utilities - Pooled	Accumulated Cost	#####	357 Nurs. Fac.	2,777,349		2,436,211	3,274
5	10	Nursing - Direct	Accumulated Cost	#####	357 Nurs. Fac.	6,096,791	4,282,378	2,436,211	8,178
6	10	Nursing - Pooled	Accumulated Cost	#####	357 Nurs. Fac.	5,221,432	3,383,186	2,436,211	6,155
7	17	General & Admin. - Direct	Accumulated Cost	#####	357 Nurs. Fac.	23,025,730	19,694,773	2,436,211	30,884
8	17	General & Admin. - Pooled	Accumulated Cost	#####	357 Nurs. Fac.	82,128,599	31,955,235	2,436,211	96,812
9	22	Employee Benefits - Direct	Accumulated Cost	#####	357 Nurs. Fac.	2,724,065		2,436,211	3,654
10	22	Employee Benefits - Pooled	Accumulated Cost	#####	357 Nurs. Fac.	(9,534,453)		2,436,211	(11,241)
11	30	Depreciation - Direct	Accumulated Cost	#####	357 Nurs. Fac.	74,480		2,436,211	100
12	30	Depreciation - Pooled	Accumulated Cost	#####	357 Nurs. Fac.	16,563,680		2,436,211	19,525
13									13
14		Interest				14,161,817			14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 144,173,315	\$ 59,723,108	\$	158,485

[Print Previe](#)

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		X	Finance Capital Additions	N/A		\$ 835,413	\$ 835,413		7.656%	\$ 63,960	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 835,413	\$ 835,413			\$ 63,960	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 835,413	\$ 835,413			\$ 63,960	15								

* 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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Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/00

Ending:

12/31/00

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	<u>43,552</u>	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.)	\$	<u>42,064</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>(1,488)</u>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>42,064</u>	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 used previously to calculate a payment rate. 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 19 _____ 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	\$	<u>40,576</u>	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	<u>43,254</u>	8
	1996	<u>40,888</u>	9
	1997	<u>42,724</u>	10
	1998	<u>43,552</u>	11
	1999	<u>42,064</u>	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	\$	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.

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Facility Name & ID Numbr Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,714 B. General Construction Type: Exterior Masonry Frame Steel, Fire resistant 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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	Facility		1983	\$ 54,305	1
2					2
3	TOTALS			\$ 54,305	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

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Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	69		1964	1964	\$ 407,801	\$	30	\$	\$	\$ 407,801	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	CURRENT YEAR DEPRECIATION					83,688		83,688		505,647	9
10	Building Improvements		1968		73						10
11	Building Improvements		1969		1,059						11
12	Building Improvements		1970		1,083						12
13	Building Improvements		1971		10,602						13
14	Building Improvements		1972		5,946						14
15	Building Improvements		1973		758						15
16	Building Improvements		1974		817						16
17	Building Improvements		1975		3,645						17
18	Building Improvements		1978		19,333						18
19	Land Improvements		1983		1,350						19
20	Building Improvements		1984		21,913						20
21	Building Improvements		1985		42,479						21
22	Land Improvements		1985		8,457						22
23	Building Improvements		1986		23,347						23
24	Land Improvements		1986		2,349						24
25	Building Improvements		1987		19,172						25
26	Building Improvements		1988		14,265						26
27	Land Improvements		1988		1,470						27
28	Building Improvements		1989		36,615						28
29	Land Improvements		1990		1,500						29
30	Building Improvements		1990		27,793						30
31	Building Improvements		1991		9,501						31
32	Building Improvements		1992		24,536						32
33	Building Improvements		1993		16,600						33
34	Land Improvements		1994		3,095						34
35	Building Improvements		1994		1,278						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 83,688		\$ 83,688	\$	\$ 913,448	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Page 12A

Facility Name & ID Numbe Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		Land Improvements		1995	1,098						9
10		Building Improvements		1995	14,214						10
11		Building Improvements: Renovation of 4 bed area: Architect and		1996	23,693						11
12		engineering fees, demolition, masonary, concrete, drywall,									12
13		windows, doors, wood trim, paint, counter tops, electrical									13
14		Building Improvements : Wallcovering		1996	79,684						14
15		Building Improvements : Carpet and vinyl		1996	33,131						15
16		Building Improvements : Ceramic flooring		1996	40,886						16
17		Building Improvements : Millwork		1996	25,990						17
18		Building Improvements : Electrical lighting, plumbing fixtures, h		1996	51,580						18
19		rails, mirrors, lighting fixtures, signs, upgrade of alarm system,									19
20		vinyl flooring									20
21		Building Improvements : Doors		1997	10,728						21
22		Building Improvements : Electrical composite, automatic doors,		1997	38,947						22
23		metal doors, fire alarm system									23
24		Building Improvements : Capalo		1997	2,500						24
25		Building Improvements : Generator		1997	7,743						25
26		Building Improvements : Heating, Ventilation, Air Conditioning		1997	466,556						26
27		Building Improvements : Onan Genator		1997	17,482						27
28		Building Improvements : Soffits, gutters & trim		1997	9,962						28
29		Building Improvements : Generator		1997	24,885						29
30		Land Improvements - Sidewald		1998	7,988						30
31		Building Improvements - Fire Prevention System		1998	35,013						31
32		Building Improvements - HVAC		1997	42,499						32
33		Sidewalk		1999	7,988						33
34		Sidewalk		1999	900						34
35											35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$	\$	\$	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Page 12B

Facility Name & ID Numbe Heartland Health Care Center-Galesburg

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Report Period Beginning:

01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9		Overhead from const		1999	2,681						9
10		Power control wiring for ne		1999	2,392						10
11		Sprinkler system upgrade		1999	19,107						11
12		Air compressor		1999	598						12
13		Laundry room floor		1999	1,800						13
14		Sprinkler upgrade		1999	23,940						14
15		Fire sprinkler system		1999	2,971						15
16		Boiler		1999	33,600						16
17		HVAC upgrade		1999	2,420						17
18		Building improvements		1999	1,200						18
19		SMOKING HUT		2000	4,950						19
20		CONCRETE FOR SMOKE HUT		2000	350						20
21		CABINETRY		2000	3,690						21
22		ELECTRICAL		2000	20,205						22
23		ADDT'L COST SMOKING HUT		2000	645						23
24		ELECTRICAL		2000	10,880						24
25		ELECTRICAL		2000	3,454						25
26		HVAC		2000	21,662						26
27		ELECTRICAL/NEW OFFICE		2000	860						27
28		CABINETS		2000	1,369						28
29		HVAC		2000	1,736						29
30		HVAC		2000	193						30
31		ADDT'L COST FOR SPRINKLER SYST		2000	15,146						31
32											32
33											33
34											34
35											35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$	\$	\$	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.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Numbe Heartland Health Care Center-Galesburg

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01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	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.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Page 12D

Facility Name & ID Numbe Heartland Health Care Center-Galesburg

0041806

Report Period Beginning:

01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	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.

Print Previe

Facility Name & ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	Componer Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 705,771	\$ 39,569	\$ 39,569	\$		\$ 521,117	37
38	Current Year Purchases	55,515						38
39	Fully Depreciated Assets							39
40	H/O Allocation		19,625	19,625				40
41	TOTALS	\$ 761,286	\$ 59,194	\$ 59,194	\$		\$ 521,117	41

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	
42	Transporting Residents	1986 Chevy Van with lift	1986	\$ 20,718	\$	\$	\$		\$ 20,718	42
43										43
44										44
45										45
46	TOTALS			\$ 20,718	\$	\$	\$		\$ 20,718	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 142,882	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 142,882	49**
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,455,283	51

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* 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.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	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 equipm: \$ 5,916 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
 (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 curre
 rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

* 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.

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Facility Name & ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/00 Ending: 12/31/00

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	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 Nurse Aide 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 aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

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

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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	10a	3,554 hrs	\$ 69,049	151	\$ 3,781	\$ 990	3,705	\$ 73,820	1
2	Licensed Speech and Language Development Therapist	10a	1,072 hrs	21,435	58	1,457	43	1,130	22,935	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	3,402 hrs	54,833	240	6,001	690	3,642	61,524	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescripts			3,632	214,020		217,652	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S - Lab,Dentist,Ph	10,Col.3, 39				10,827	456		11,283	13
14	TOTAL			\$ 145,317	449	\$ 25,698	\$ 216,199	8,477	\$ 387,214	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Heartland Health Care Center-Galesburg

0041806

Report Period Beginning: 01/01/00

Ending:

12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

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	\$ (16,041)	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (37,224))	501,779	3
4	Supply Inventory (priced at)	16,034	4
5	Short-Term Investments		5
6	Prepaid Insurance		6
7	Other Prepaid Expenses	520	7
8	Accounts Receivable (owners or related parties)		8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 502,292	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	90,500	13
14	Buildings, at Historical Cost	1,789,956	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	782,004	16
17	Accumulated Depreciation (book methods)	(1,455,283)	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)	\$ 1,207,177	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,709,469	25

	1	2	
	Operating	After	
		Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 45,109	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits		28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	85,220	30
31	Accrued Taxes Payable (excluding real estate taxes)	90	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,064	32
33	Accrued Interest Payable		33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	Other Accrued Expenses	8,092	36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 180,575	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable	835,413	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)	\$ 835,413	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,015,988	46
47	TOTAL EQUITY(page 18, line 24)	\$ 693,481	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,709,469	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 585,240	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 585,240	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	614,295	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)	\$ 614,295	17
B. Transfers (Itemize):			
18	Change in Interdivision	(506,054)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (506,054)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 693,481	24 *

* This must agree with page 17, line 47.

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Facility Name & ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/00 Ending: 12/31/00

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	\$ 2,662,246	1
2	Discounts and Allowances for all Levels	(222,527)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,439,719	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	454,695	6
7	Oxygen	2,085	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 456,780	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,522	12
13	Barber and Beauty Care	7,275	13
14	Non-Patient Meals	517	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	36	16
17	Sale of Drugs	221,498	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,393	19
20	Radiology and X-Ray	1,425	20
21	Other Medical Services	3,778	21
22	Laundry	6,523	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 266,967	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 3,163,466	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 433,890	31
32	Health Care	1,022,323	32
33	General Administration	547,491	33
B. Capital Expense			
34	Ownership	243,422	34
C. Ancillary Expense			
35	Special Cost Centers	302,045	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)*	\$ 2,549,171	40
41	Income before Income Taxes (line 30 minus line 40)**	614,295	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 614,295	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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