



Facility Name & ID Number HEARTLAND HEALTH CARE CTR-GALESBRG

# 0041806 Report Period Beginning: 01/01/02 Ending: 12/31/02

**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	25,185	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	25,185	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	4 Other		
8	SNF	1,183	452	5,669	7,304	8
9	SNF/PED					9
10	ICF	5,433	7,575	1,724	14,732	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,616	8,027	7,393	22,036	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.50%

D. How many bed-hold days during this year were paid by Public Aid? 58 (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)  
N/A

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 4/01/86 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 22 and days of care provided 4,745

Medicare Intermediary AdminaStar Federal

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/02 Fiscal Year: 12/31/02

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

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number HEARTLAND HEALTH CARE CTR-GALE # 0041806 Report Period Beginning: 01/01/02 Ending: 12/31/02

## 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
	<b>A. General Services</b>										
1	Dietary	109,519	7,936	468	117,923	1,163	119,086		119,086		1
2	Food Purchase		109,297		109,297		109,297	(2,110)	107,187		2
3	Housekeeping	54,897	11,156	684	66,737		66,737		66,737		3
4	Laundry	26,530	7,408	154	34,092		34,092		34,092		4
5	Heat and Other Utilities			85,305	85,305	4,739	90,044	(2,037)	88,007		5
6	Maintenance	32,475	8,559	20,125	61,159		61,159		61,159		6
7	Other (specify):* Med Waste			1,655	1,655		1,655		1,655		7
8	<b>TOTAL General Services</b>	223,421	144,356	108,391	476,168	5,902	482,070	(4,147)	477,923		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,250	10,250		10,250		10,250		9
10	Nursing and Medical Records	820,746	78,358	13,576	912,680	20,192	932,872		932,872		10
10a	Therapy	220,949	1,545	15,739	238,233		238,233		238,233		10a
11	Activities	34,173	3,264	1,928	39,365		39,365		39,365		11
12	Social Services	60,072	296	1,128	61,496		61,496		61,496		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,135,940	83,463	42,621	1,262,024	20,192	1,282,216		1,282,216		16
	<b>C. General Administration</b>										
17	Administrative	56,755		198,217	254,972	(85,361)	169,611		169,611		17
18	Directors Fees										18
19	Professional Services			20,198	20,198		20,198	(20,198)			19
20	Dues, Fees, Subscriptions & Promotions			34,530	34,530		34,530	(25,299)	9,231		20
21	Clerical & General Office Expenses	98,221	30,413	109,493	238,127		238,127	(102,143)	135,984		21
22	Employee Benefits & Payroll Taxes			443,173	443,173	36,310	479,483		479,483		22
23	Inservice Training & Education			1,120	1,120		1,120		1,120		23
24	Travel and Seminar			17,568	17,568		17,568		17,568		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			54,054	54,054		54,054		54,054		26
27	Other (specify):* Pers. Purchase			84	84		84		84		27
28	<b>TOTAL General Administration</b>	154,976	30,413	878,437	1,063,826	(49,051)	1,014,775	(147,640)	867,135		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,514,337	258,232	1,029,449	2,802,018	(22,957)	2,779,061	(151,787)	2,627,274		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.

STATE OF ILLINOIS

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-GALESBRG #0041806 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			143,703	143,703	22,957	166,660		166,660		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			25,898	25,898		25,898		25,898		32
33	Real Estate Taxes			48,166	48,166		48,166	2,587	50,753		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			27,071	27,071		27,071		27,071		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			244,838	244,838	22,957	267,795	2,587	270,382		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		257,019	8,136	265,155		265,155		265,155		39
40	Barber and Beauty Shops			7,518	7,518		7,518		7,518		40
41	Coffee and Gift Shops	20,181			20,181		20,181		20,181		41
42	Provider Participation Fee			37,777	37,777		37,777		37,777		42
43	Other (specify):*		21,118		21,118		21,118		21,118		43
44	<b>TOTAL Special Cost Centers</b>	20,181	278,137	53,431	351,749		351,749		351,749		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,534,518	536,369	1,327,718	3,398,605		3,398,605	(149,200)	3,249,405		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.)

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,110)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,037)	5		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	(14)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(723)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(101)	21		16
17	Non-Care Related Fees	(4,492)	21		17
18	Fines and Penalties	(10,000)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(20,198)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(86,813)	21		24
25	Fund Raising, Advertising and Promotional	(25,299)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	2,587	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (149,200)		\$	30

<b>OHF USE ONLY</b>					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (149,200)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

HEARTLAND HEALTH CARE CTR-GALESBRG

ID# 0041806

Report Period Beginning: 01/01/02

Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
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
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number HEARTLAND HEALTH CARE CTR-GALESBRG

# 0041806 Report Period Beginning:

01/01/02

Ending:

12/31/02

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,110)	0	0	0	0	0	0	0	0	0	0	(2,110)	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	(2,037)	0	0	0	0	0	0	0	0	0	0	(2,037)	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	<b>TOTAL General Services</b>	<b>(4,147)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,147)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(20,198)	0	0	0	0	0	0	0	0	0	0	(20,198)	19
20	Fees, Subscriptions & Promotions	(25,299)	0	0	0	0	0	0	0	0	0	0	(25,299)	20
21	Clerical & General Office Expenses	(102,143)	0	0	0	0	0	0	0	0	0	0	(102,143)	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	<b>TOTAL General Administration</b>	<b>(147,640)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(147,640)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(151,787)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(151,787)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/02 Ending: 12/31/02

## 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)
	<b>D. Ownership</b>												
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	2,587	0	0	0	0	0	0	0	0	0	0	2,587 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	<b>TOTAL Ownership</b>	<b>2,587</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,587 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(149,200)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(149,200) 45</b>

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O Cost Report)	Toledo,OH			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See						1
2	V	Page						2
3	V	8						3
4	V							4
5	V							5
6	V	10a						6
		Home Office Allocation	\$ 198,217	HCR Manor Care, Inc.	100.00%	\$ 198,217	\$	
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 213,217			\$ 213,217	\$ *	14

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

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-GAL # 0041806 Report Period Beginning: 01/01/02 Ending: 12/31/02

## 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	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 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 HEARTLAND HEALTH CARE CTR-GALESBRG # 0041806 Report Period Beginning: 01/01/02 Ending: 12/31/02

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 Manor Care, Inc.  
 Street Address 333 North Summit St.  
 City / State / Zip Code Toledo, OH. 43604  
 Phone Number (419)252-5500  
 Fax Number (419)254-5494

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)		
1	1	Dietary - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	\$ 0	\$ 3,383,714	\$ 0	1	
2	1	Dietary - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	920,912	536,824	1,163	2	
3	5	Utilities - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	112,862	3,383,714	168	3	
4	5	Utilities - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	3,618,915	3,383,714	4,571	4	
5	10	Nursing - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	11,131,912	7,408,777	3,383,714	16,601	5
6	10	Nursing - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	2,842,925	1,812,855	3,383,714	3,591	6
7	17	General & Admin - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	19,326,083	15,188,841	3,383,714	28,822	7
8	17	General & Admin - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	66,522,981	38,146,902	3,383,714	84,033	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	2,749,439	3,383,714	4,100	9	
10	22	Employee Benefits - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	25,498,075	3,383,714	32,210	10	
11	30	Depreciation - Direct	Accumulated Cost	2,268,919,616	369 Nurs. Fac.	148,355	3,383,714	221	11	
12	30	Depreciation - Pooled	Accumulated Cost	2,678,646,988	369 Nurs. Fac.	17,998,306	3,383,714	22,737	12	
13									13	
14	32	Interest				7,352,132		0	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 158,222,897	\$ 63,094,199	\$ 198,217	25	

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-GALE # 0041806 Report Period Beginning: 01/01/02 Ending: 12/31/02

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		<b>A. Directly Facility Related</b>																	
		<b>Long-Term</b>																	
1		Bank of America		X	Finance Capital Additions	N/A		\$ 835,413	\$ 964,387			\$ 25,898	1						
2													2						
3													3						
4													4						
5													5						
		<b>Working Capital</b>																	
6													6						
7													7						
8													8						
9		<b>TOTAL Facility Related</b>						\$ 835,413	\$ 964,387			\$ 25,898	9						
		<b>B. Non-Facility Related*</b>																	
10													10						
11													11						
12													12						
13													13						
14		<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15		<b>TOTALS (line 9+line14)</b>						\$ 835,413	\$ 964,387			\$ 25,898	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

Facility Name & ID Number **HEARTLAND HEALTH CARE CTR-GALESBRG**# **0041806** Report Period Beginning: **01/01/02** Ending: **12/31/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2001 report.		\$	45,579	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.)		\$	48,166	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	2,587	3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	48,166	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	50,753	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	42,724	8	
		1998	43,552	9	
		1999	42,064	10	
		2000	45,579	11	
		2001	48,166	12	
<b>FOR OHF USE ONLY</b>					
13	FROM R. E. TAX STATEMENT FOR 2001	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME HEARTLAND HEALTH CARE CTR-GALESBRG COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0041806

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

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

Enter the tax index number and real estate tax assessed for 2001 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 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>9910427016</u>	<u>See Attached</u>	<u>\$ 48,166.00</u>	<u>\$ 48,166.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	<u>\$ 48,166.00</u>	<u>\$ 48,166.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,716 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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1983</u>	<u>\$ 54,305</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 54,305</b>	<b>3</b>

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-GALESBRG

# 0041806

Report Period Beginning:

01/01/02

Ending:

12/31/02

**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	\$ 13,848	30	\$ 13,848	\$	\$ 407,801
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	<b>Building Improvements (Current Year Depreciation)</b>				79,789		79,789		664,449
10	Building Improvements	1968		73					
11	Building Improvements	1969		1,059					
12	Building Improvements	1970		1,083					
13	Building Improvements	1971		10,602					
14	Building Improvements	1972		5,946					
15	Building Improvements	1973		758					
16	Building Improvements	1974		817					
17	Building Improvements	1975		3,645					
18	Building Improvements	1978		19,333					
19	Land Improvements	1983		1,350					
20	Building Improvements	1984		21,913					
21	Building Improvements	1985		42,479					
22	Land Improvements	1985		8,457					
23	Building Improvements	1986		23,347					
24	Land Improvements	1986		2,349					
25	Building Improvements	1987		19,172					
26	Building Improvements	1988		14,265					
27	Land Improvements	1988		1,470					
28	Building Improvements	1989		36,615					
29	Land Improvements	1990		1,500					
30	Building Improvements	1990		27,793					
31	Building Improvements	1991		9,501					
32	Building Improvements	1992		24,536					
33	Building Improvements	1993		16,600					
34	Land Improvements	1994		3,095					
35	Building Improvements	1994		1,278					
36									

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number HEARTLAND HEALTH CARE CTR-GALESBRG

# 0041806

Report Period Beginning:

01/01/02

Ending:

12/31/02

## XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Land Improvements	1995	\$ 1,098	\$		\$	\$	\$		37
38	Building Improvements	1995	14,214							38
39	Building Improvements: Renovation of 4 bed area: Architect and	1996	23,693							39
40	engineering fees, demolition, masonry, concrete, drywall,									40
41	windows, doors, wood trim, paint, counter tops, electrical									41
42	Building Improvements : Wallcovering	1996	79,684							42
43	Building Improvements : Carpet and vinyl	1996	33,131							43
44	Building Improvements : Ceramic flooring	1996	40,886							44
45	Building Improvements : Millwork	1996	25,990							45
46	Building Improvements : Electrical lighting, plumbing fixtures, hand	1996	51,580							46
47	rails, mirrors, lighting fixtures, signs, upgrade of alarm system,									47
48	vinyl flooring									48
49	Building Improvements : Doors	1997	10,728							49
50	Building Improvements : Electrical composite, automatic doors,	1997	38,947							50
51	metal doors, fire alarm system									51
52	Building Improvements : Capalo	1997	2,500							52
53	Building Improvements : Generator	1997	7,743							53
54	Building Improvements : Heating, Ventilation, Air Conditioning	1997	466,556							54
55	Building Improvements : Onan Genator	1997	17,482							55
56	Building Improvements : Soffits, gutters & trim	1997	9,962							56
57	Building Improvements : Generator	1997	24,885							57
58	Land Improvements - Sidewalk	1998	7,988							58
59	Building Improvements - Fire Prevention System	1998	35,013							59
60	Building Improvements - HVAC	1997	42,499							60
61	Sidewalk	1999	7,988							61
62	Sidewalk	1999	900							62
63	Overhead from const	1999	2,681							63
64	Power control wiring for ne	1999	2,392							64
65	Sprinkler system upgrade	1999	19,107							65
66	Air compressor	1999	598							66
67	Laundry room floor	1999	1,800							67
68	Sprinkler upgrade	1999	23,940							68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,700,822	\$ 93,637		\$ 93,637	\$	\$ 1,072,250		70

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

STATE OF ILLINOIS

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-GALESBRG

# 0041806

Report Period Beginning:

01/01/02

Ending:

Page 12B

12/31/02

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 1,700,822	\$ 93,637		\$ 93,637		\$ 1,072,250		1
2	Fire sprinkler system	1999 2,971							2
3	Boiler	1999 33,600							3
4	HVAC upgrade	1999 2,420							4
5	Building improvements	1999 1,200							5
6	SMOKING HUT	2000 4,950							6
7	CONCRETE FOR SMOKE HUT	2000 350							7
8	CABINETRY	2000 3,690							8
9	ELECTRICAL	2000 20,205							9
10	ADDT'L COST SMOKING HUT	2000 645							10
11	ELECTRICAL	2000 10,880							11
12	ELECTRICAL	2000 3,454							12
13	HVAC	2000 21,662							13
14	ELECTRICAL/NEW OFFICE	2000 860							14
15	CABINETS	2000 1,369							15
16	HVAC	2000 1,736							16
17	HVAC	2000 193							17
18	ADDT'L COST FOR SPRINKLER SYST	2000 15,146							18
19	AIR / HUMIDIFIER COIL	2001 5,233							19
20	CANOPY	2001 1,200							20
21	CONCRETE PATIO	2001 5,500							21
22	VWC	2002 1,172							22
23	Carpet	2002 1,534							23
24	Roof Upgrade	2002 98,494							24
25	Border	2002 111							25
26	Border	2002 125							26
27	Brick Work	2002 5,787							27
28	Addition Cost Brick Work	2002 643							28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,945,950	\$ 93,637		\$ 93,637		\$ 1,072,250		34

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

STATE OF ILLINOIS

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-GALESBRG

# 0041806

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,945,950	\$ 93,637		\$ 93,637	\$	\$ 1,072,250	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
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22									22
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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)		\$ 1,945,950	\$ 93,637		\$ 93,637	\$	\$ 1,072,250	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 832,911	\$ 50,066	\$ 50,066	\$		\$ 615,890	71
72	Current Year Purchases	64,990						72
73	Fully Depreciated Assets							73
74	Home Office Allocation		22,957	22,957				74
75	TOTALS	\$ 897,901	\$ 73,023	\$ 73,023	\$		\$ 615,890	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,898,156	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 166,660	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 166,660	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,688,140	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

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

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

Fiscal Year Ending      Annual Rent

12. \_\_\_\_\_ /2003 \$ \_\_\_\_\_  
13. \_\_\_\_\_ /2004 \$ \_\_\_\_\_  
14. \_\_\_\_\_ /2005 \$ \_\_\_\_\_

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: \$ 19,002 Description: 02 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	<u>Resident Transportation</u>	<u>1997 Ford Van</u>	\$ <u>721.42</u>	\$ <u>8,069</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>721.42</u>	\$ <u>8,069</u>	21

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

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

**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><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER 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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the 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.

- (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.

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	4941 hrs	\$ 115,964	249	\$ 6,222	\$ 523	5,190	\$ 122,709	1
2	Licensed Speech and Language Development Therapist	10A	730 hrs	17,133	78	1,950	40	808	19,123	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	3743 hrs	87,852	295	7,371	982	4,038	96,205	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				257,019		257,019	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 X-Ray, Lab	10a,39,Col.3			333	8,332		333	8,332	13
14	TOTAL			\$ 220,949	955	\$ 23,875	\$ 258,564	10,369	\$ 503,388	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.

Facility Name & ID Number **HEARTLAND HEALTH CARE CTR-GALESBRG** # **0041806** Report Period Beginning: **01/01/02** Ending: **12/31/02**  
**XV. BALANCE SHEET - Unrestricted Operating Fund.** As of **12/31/02** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ 10,438	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (106,774) )		772,281	3
4	Supply Inventory (priced at )		15,240	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		690	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$ 798,649	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		54,305	13
14	Buildings, at Historical Cost		1,945,949	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		897,902	16
17	Accumulated Depreciation (book methods)		(1,688,140)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 1,210,016	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$ 2,008,665	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 23,718	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,833		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,166		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Expenses</u>	50,114		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 239,831	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	964,387		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 964,387	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,204,218	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 804,447	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,008,665	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>829,562</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>829,562</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	493,758	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>493,758</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Change In Interdivision</b>	(518,873)	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(518,873)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>804,447</b>	<b>24 *</b>

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,088,190	1
2	Discounts and Allowances for all Levels	(278,979)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,809,211	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	762,381	6
7	Oxygen	7,073	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 769,454	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	475	12
13	Barber and Beauty Care	8,533	13
14	Non-Patient Meals	1,652	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	262,598	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,115	19
20	Radiology and X-Ray	2,992	20
21	Other Medical Services	908	21
22	Laundry	8,919	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 309,192	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,492	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,492	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Misc Income</b>	14	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 14	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,892,363	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	476,168	31
32	Health Care	1,262,024	32
33	General Administration	1,063,826	33
<b>B. Capital Expense</b>			
34	Ownership	244,838	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	351,749	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,398,605	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	493,758	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 493,758	43

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

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

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

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

Facility Name & ID Number HEARTLAND HEALTH CARE CTR-GALESBRG

# 0041806

Report Period Beginning: 01/01/02

Ending:

12/31/02

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	1,309	1,407	\$ 31,073	\$ 22.08	1
2	Assistant Director of Nursing	2,981	3,204	60,521	18.89	2
3	Registered Nurses	4,010	4,310	78,018	18.10	3
4	Licensed Practical Nurses	14,111	15,167	210,998	13.91	4
5	Nurse Aides & Orderlies	44,894	48,254	427,077	8.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	8,894	9,415	220,949	23.47	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,226	3,472	34,173	9.84	9
10	Activity Assistants					10
11	Social Service Workers	3,898	4,192	60,072	14.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,384	14,346	109,519	7.63	15
16	Dishwashers					16
17	Maintenance Workers	2,102	2,257	32,475	14.39	17
18	Housekeepers	7,181	7,728	54,897	7.10	18
19	Laundry	3,231	3,480	26,530	7.62	19
20	Administrator	2,307	2,080	56,755	27.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,176	10,104	118,402	11.72	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	1,572	1,690	13,059	7.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,276	131,106	\$ 1,534,518 *	\$ 11.70	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	\$		35
36	Medical Director	Monthly 10,250	5,9,3	36
37	Medical Records Consultant	Monthly 1,475	5,10,3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 8,143	5,10,3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant	Monthly 21	5,10a,3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	Monthly 1,866	5,11,3	44
45	Social Service Consultant	Monthly 1,128	5,12,3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,883		49

C. CONTRACT NURSES

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





XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA \$3,191
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,816 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)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Galesburg Nursing & Rehab Center #29504. Tranferred to HCR 8/15/96
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 37,777  
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 of Public Aid, 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? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,652
- (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? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
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? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.