



Facility Name & ID Number Heritage Manor East-Beardstown

# 0041632 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

**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	71	Skilled (SNF)	71	25,915	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	71	TOTALS	71	25,915	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	Other		
8	SNF	13,597	4,696	757	19,050	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	13,597	4,696	757	19,050	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.51%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
NONE

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 05/01/96

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 05/01/96 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided 757

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_  
\* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	100,266	7,962		108,228		108,228	2,433	110,661		1
2	Food Purchase		68,275		68,275		68,275	(857)	67,418		2
3	Housekeeping	50,309	6,448		56,757		56,757		56,757		3
4	Laundry	20,937	10,221		31,158		31,158		31,158		4
5	Heat and Other Utilities			40,396	40,396		40,396	757	41,153		5
6	Maintenance	21,732	13,571	18,394	53,697		53,697	6,546	60,243		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	193,244	106,477	58,790	358,511		358,511	8,879	367,390		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	626,564	25,183	39,317	691,064		691,064		691,064		10
10a	Therapy		63,043	38,566	101,609	(204,815)	(103,206)	137,819	34,613		10a
11	Activities	25,206	1,074		26,280		26,280		26,280		11
12	Social Services	8,476		3,151	11,627		11,627		11,627		12
13	Nurse Aide Training	200			200		200	1,352	1,552		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	660,446	89,300	81,034	830,780	(204,815)	625,965	139,171	765,136		16
	<b>C. General Administration</b>										
17	Administrative	46,215			46,215		46,215	62,871	109,086		17
18	Directors Fees							3,337	3,337		18
19	Professional Services			122,873	122,873		122,873	(116,591)	6,282		19
20	Dues, Fees, Subscriptions & Promotions			54,235	54,235	(38,873)	15,362	(3,892)	11,470		20
21	Clerical & General Office Expenses	44,960	4,800	11,899	61,659		61,659	132,242	193,901		21
22	Employee Benefits & Payroll Taxes			135,388	135,388		135,388	17,292	152,680		22
23	Inservice Training & Education			1,456	1,456		1,456	543	1,999		23
24	Travel and Seminar			2,021	2,021		2,021	(22)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			29,501	29,501		29,501	1,274	30,775		26
27	Other (specify):*			1,076	1,076		1,076	(1,028)	48		27
28	<b>TOTAL General Administration</b>	91,175	4,800	358,449	454,424	(38,873)	415,551	96,026	511,577		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	944,865	200,577	498,273	1,643,715	(243,688)	1,400,027	244,076	1,644,103		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.

Facility Name &amp; ID Number

Heritage Manor East-Beardstown

#0041632

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

## 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			107,817	107,817		107,817	6,213	114,030			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			74,262	74,262		74,262	55	74,317			32
33	Real Estate Taxes			22,917	22,917		22,917		22,917			33
34	Rent-Facility & Grounds							4,771	4,771			34
35	Rent-Equipment & Vehicles			3,211	3,211		3,211	9,010	12,221			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			208,207	208,207		208,207	20,049	228,256			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					204,815	204,815		204,815			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					38,873	38,873		38,873			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>					243,688	243,688		243,688			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	944,865	200,577	706,480	1,851,922		1,851,922	264,125	2,116,047			45

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

Facility Name & ID Number Heritage Manor East-Beardstown

# 0041632

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

**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 Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(427)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(101)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(857)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(1,232)	20		17
18	Fines and Penalties				18
19	Entertainment	(4,248)	24		19
20	Contributions	(1,028)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(260)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(5,247)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real estate taxes		33		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (13,400)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	277,525		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 277,525		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 264,125		37

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

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

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

Heritage Manor East-Beardstown

ID# 0041632

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	\$	0	0	1
2		0	0	2
3		0	0	3
4		0	0	4
5		(427)	35	5
6		0	34	6
7		0		7
8		0		8
9		0	30	9
10			32	10
11		0		11
12		0		12
13		(857)	2	13
14		0	32	14
15		0	33	15
16		0	24	16
17		(1,232)	20	17
18		0		18
19			24	19
20		(1,028)	27	20
21		0		21
22		(260)	19	22
23		0		23
24		0	27	24
25		(5,247)	20	25
26		0	0	26
27		0	0	27
28		0	0	28
29		0	0	29
30		0	0	30
31		0	0	31
32				32
33		0	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>	(9,051)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor East-Beardstown

# 0041632 Report Period Beginning:

1/01/2002

Ending:

12/31/2002

## 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	2,433	0	0	0	0	0	0	0	0	2,433	1
2	Food Purchase	(857)	0	0	0	0	0	0	0	0	0	0	(857)	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	757	0	0	0	0	0	0	0	0	757	5
6	Maintenance	0	0	6,546	0	0	0	0	0	0	0	0	6,546	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(857)</b>	<b>0</b>	<b>9,736</b>	<b>0</b>	<b>8,879</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	137,819	0	0	0	0	0	0	0	0	0	137,819	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	1,352	0	0	0	0	0	0	0	0	1,352	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>137,819</b>	<b>1,352</b>	<b>0</b>	<b>139,171</b>	<b>16</b>							
	<b>C. General Administration</b>													
17	Administrative	0	0	62,871	0	0	0	0	0	0	0	0	62,871	17
18	Directors Fees	0	0	3,337	0	0	0	0	0	0	0	0	3,337	18
19	Professional Services	(260)	(122,613)	6,282	0	0	0	0	0	0	0	0	(116,591)	19
20	Fees, Subscriptions & Promotions	(6,479)	0	2,587	0	0	0	0	0	0	0	0	(3,892)	20
21	Clerical & General Office Expenses	0	0	132,242	0	0	0	0	0	0	0	0	132,242	21
22	Employee Benefits & Payroll Taxes	0	0	17,292	0	0	0	0	0	0	0	0	17,292	22
23	Inservice Training & Education	0	0	543	0	0	0	0	0	0	0	0	543	23
24	Travel and Seminar	(4,248)	0	4,226	0	0	0	0	0	0	0	0	(22)	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	1,274	0	0	0	0	0	0	0	0	1,274	26
27	Other (specify):*	(1,028)	0	0	0	0	0	0	0	0	0	0	(1,028)	27
28	<b>TOTAL General Administration</b>	<b>(12,015)</b>	<b>(122,613)</b>	<b>230,654</b>	<b>0</b>	<b>96,026</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(12,872)</b>	<b>15,206</b>	<b>241,742</b>	<b>0</b>	<b>244,076</b>	<b>29</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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization		GreenTree Therapy	100.00%			2
3	V							3
4	V	19 Adjustment for Related Organization	122,613	Heritage Enterprises, Inc.	100.00%		(122,613)	4
5	V							5
6	V	10a Adjustment for Related Organization	65,550	GreenTree Pharmacy	100.00%	203,369	137,819	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 188,163			\$ 203,369	\$ * 15,206	14

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

Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 2,433	\$	2,433	15
16	V	2 Food Purchase				0			16
17	V	3 Housekeeping				0			17
18	V	4 Laundry				0			18
19	V	5 Heat & Other Utilities				757		757	19
20	V	6 Maintenance				6,546		6,546	20
21	V	7 Other				0			21
22	V	9 Medical Director				0			22
23	V	10 Nursing & Medical Records				0			23
24	V	11 Activities				0			24
25	V	12 Social Service				0			25
26	V	13 Nurse Aide Training				1,352		1,352	26
27	V	14 Program Transportation				0			27
28	V	15 Other				0			28
29	V	17 Administrative				62,871		62,871	29
30	V	18 Directors Fees				3,337		3,337	30
31	V	19 Professional Services				6,282		6,282	31
32	V	20 Fees, Subscription, Promotions				2,587		2,587	32
33	V	21 Clerical & General Office Expenses				132,242		132,242	33
34	V	22 Employee Benefits & Payroll Taxes				17,292		17,292	34
35	V	23 Inservice Training & Education				543		543	35
36	V	24 Travel and Seminar				4,226		4,226	36
37	V	25 Other Admin. Staff Transportation				0			37
38	V	26 Insurance-Prop.Liab.Malpract				1,274		1,274	38
39	Total		\$			\$ 241,742	\$ *	241,742	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	27 Other	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$
16	V	30 Depreciation				6,213	6,213
17	V	31 Amortization of Pre-Op & Org				0	
18	V	32 Interest				156	156
19	V	33 Real Estate Taxes				0	
20	V	34 Rent-Facility & Grounds				4,771	4,771
21	V	35 Rent-Equipment & Vehicles				9,437	9,437
22	V	36 Other				0	
23	V	38 Medically Nec Transportation				0	
24	V	39 Ancillary Service Centers				0	
25	V	40 Barber and Beauty Shops				0	
26	V	41 Coffee and Gift Shops				0	
27	V	42 Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 20,577	\$ * 20,577

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

Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

## 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	Bill Froelich	Chairman of Board	Management	26.00	397,396	5	100.00	Director/Salar	\$ 11,751	line 17/18, col 1
2	Tom Jefferson	Asst Secretary/Treas	Management	10.00	390,860	5	100.00	Director/Salary	11,558	line 17/18, col 2
3	Craig Hart	Secretary/Treasurer	Management	20.00	343,058	10	100.00	Director/Salary	10,145	line 17/18, col 3
4	Joe Warner	President	Management	2.50	370,366	40	100.00	Director/Salary	10,952	line 17/18, col 4
5	Bob Dickson	Executive Vice Presid	Management	0.80	92,266	40	100.00	Salary	2,728	line 17, col 7 5
6	Cheryl Lowney	Executive Vice Presid	Management	0.30	186,564	50	100.00	Director/Salary	5,517	line 17/18, col 6
7	Steve Wannemacher	Executive Vice Presid	Management	0.30	175,068	50	100.00	Director/Salary	5,177	line 17/18, col 7
8	Connie Hoselton	Sr Vice President	Management	0.17	140,191	40	100.00	Salary	4,146	line 17, col 7 8
9	Craig Ater	Sr Vice President	Management	0.21	143,176	50	100.00	Salary	4,234	line 17, col 7 9
10										10
11										11
12										12
13								TOTAL	\$ 66,208	13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 1/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 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	Beds	2,401	24	\$ 82,266	\$ 71	\$ 2,433	1
2	2	Food Purchase	Beds	2,401	24	0	71	0	2
3	3	Housekeeping	Beds	2,401	24	0	71	0	3
4	4	Laundry	Beds	2,401	24	0	71	0	4
5	5	Heat & Other Utilities	Beds	2,401	24	25,593	71	757	5
6	6	Maintenance	Beds	2,401	24	221,381	71	6,546	6
7	7	Other	Beds	2,401	24	0	71	0	7
8	9	Medical Director	Beds	2,401	24	0	71	0	8
9	10	Nursing & Medical Records	Beds	2,401	24	0	71	0	9
10	11	Activities	Beds	2,401	24	0	71	0	10
11	12	Social Service	Beds	2,401	24	0	71	0	11
12	13	Nurse Aide Training	Beds	2,401	24	45,737	71	1,352	12
13	14	Program Transportation	Beds	2,401	24	0	71	0	13
14	15	Other	Beds	2,401	24	0	71	0	14
15	17	Administrative	Beds	2,401	24	2,126,096	71	62,871	15
16	18	Directors Fees	Beds	2,401	24	112,849	71	3,337	16
17	19	Professional Services	Beds	2,401	24	212,454	71	6,282	17
18	20	Fees, Subscription, Promotions	Beds	2,401	24	87,500	71	2,587	18
19	21	Clerical & General Office Expense	Beds	2,401	24	4,472,002	71	132,242	19
20	22	Employee Benefits & Payroll Tax	Beds	2,401	24	584,769	71	17,292	20
21	23	Inservice Training & Education	Beds	2,401	24	18,362	71	543	21
22	24	Travel and Seminar	Beds	2,401	24	142,902	71	4,226	22
23	25	Other Admin. Staff Transportatio	Beds	2,401	24	0	71	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,401	24	43,070	71	1,274	24
25	TOTALS				\$ 8,174,981	\$ 6,489,559	\$	241,742	25

Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 1/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 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	27 Other	Beds	2,401	24	\$	\$	71	\$	1
2	30 Depreciation	Beds	2,401	24	210,090		71	6,213	2
3	31 Amortization of Pre-Op & Org	Beds	2,401	24			71		3
4	32 Interest	Beds	2,401	24	5,270		71	156	4
5	33 Real Estate Taxes	Beds	2,401	24			71		5
6	34 Rent-Facility & Grounds	Beds	2,401	24	161,349		71	4,771	6
7	35 Rent-Equipment & Vehicles	Beds	2,401	24	319,142		71	9,437	7
8	36 Other	Beds	2,401	24			71		8
9	38 Medically Nec Transportation	Beds	2,401	24			71		9
10	39 Ancillary Service Centers	Beds	2,401	24			71		10
11	40 Barber and Beauty Shops	Beds	2,401	24			71		11
12	41 Coffee and Gift Shops	Beds	2,401	24			71		12
13	42 Other	Beds	2,401	24			71		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 695,851	\$		\$ 20,577	25

Facility Name & ID Number Heritage Manor East-Beardstown # 0041632 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Bank One		XX	Mortgage	\$13,195.00	10/31/99	\$ 1,520,000	\$ 1,255,526	01/31/05	variable	\$ 61,646	1								
2	Bank One Loan Amortization		XX	Mortgage							454	2								
3	Central Office Allocation		XX	Interest Income								3								
4												4								
5												5								
	<b>Working Capital</b>																			
6	Central Office Allocation		xx	Working Capital							12,162	6								
7	Central Office Allocation		xx	Working Capital							156	7								
8												8								
9	TOTAL Facility Related				\$13,195.00		\$ 1,520,000	\$ 1,255,526			\$ 74,418	9								
	<b>B. Non-Facility Related*</b>																			
10	Interest Income										(101)	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (101)	14								
15	TOTALS (line 9+line14)						\$ 1,520,000	\$ 1,255,526			\$ 74,317	15								

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

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

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

Facility Name & ID Number Heritage Manor East-Beardstown# 0041632 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

## 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.	\$	21,958	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.)	\$	21,891	2															
3.	Under or (over) accrual (line 2 minus line 1).	\$	(67)	3															
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	22,984	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.	\$	22,917	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:		1997	8	<table border="1"> <tr> <td colspan="2"><b>FOR OHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2001 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		<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
<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																	
	1998	9																	
	1999	10																	
	2000	11																	
	2001	12																	

## 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 Heritage Manor East-Beardstown COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0041632

CONTACT PERSON REGARDING THIS REPORT Craig Ater

TELEPHONE (309) 823-7135 FAX #: ( )

**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>0326400700</u>	<u>Nursing Home</u>	\$ <u>21,889.00</u>	\$ <u>21,889.00</u>
2. <u>0317202001</u>	<u>Nursing Home</u>	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>21,889.00</u>	\$ <u>21,889.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 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.

Facility Name & ID Number Heritage Manor East-Beardstown# 0041632 Report Period Beginning:1/01/2002 Ending:12/31/2002

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

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

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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	Land			\$ 40,000	1
2					2
3	TOTALS			\$ 40,000	3

Facility Name & ID Number Heritage Manor East-Beardstown

# 0041632

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

**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	71			\$ 1,744,500	\$		\$	\$	\$
5									
6									
7									
8									
9	<b>Improvement Type**</b>								
10	Shower Remodel		1997	9,921					
11	Heat/Cool Units		1997	2,138					
12	Roof		1997	101,691					
13	Interior Rehab		1997	87,411					
14									
15	Five Ton Heat Pump		1996	3,257					
16	Heritage Manor Sign		1996	2,145					
17	Remodel Physical Therapy Room		1996	18,303					
18									
19	Smoke Detectors		1998	5,431					
20	Back Flow Preventers		1998	3,155					
21	Interior Rehab		1998	144,749					
22									
23	Water Heater		1999	3,991					
24	Alzheimer Unit--material		1999	51,576					
25	Alzheimer Unit--Labor		1999	14,502					
26	Alzheimer Unit--Professional Fees		1999	21,605					
27	Interior Rehab		1999	30,944					
28									
29	Alzheimer Unit--material		2000	27,447					
30	Alzheimer Unit--Labor		2000	5,812					
31	Alzheimer Unit--Professional Fees		2000	1,310					
32	Fire Alarm Panel		2001	2,026					
33	Electric Door		2001	2,378					
34	C/O Allocation						6,213	6,213	
35	Book Depreciation				74,579		74,579		446,769
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor East-Beardstown

# 0041632

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

**XI. OWNERSHIP COSTS (continued)**

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37									37
38	Heat/Cool Unit	2002	742						38
39	Heat/Cool Unit	2002	1,190						39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,286,224	\$ 74,579		\$ 80,792	\$ 6,213	\$ 446,769	70

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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor East-Beardstown

# 0041632

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

**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		\$ 2,286,224	\$ 74,579		\$ 80,792	\$ 6,213	\$ 446,769	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,286,224	\$ 74,579		\$ 80,792	\$ 6,213	\$ 446,769	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	\$ 219,088	\$ 33,238	\$ 33,238	\$		\$ 185,246	71
72	Current Year Purchases	12,230						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 231,318	\$ 33,238	\$ 33,238	\$		\$ 185,246	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)	\$ 2,557,542	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 107,817	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 114,030	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,213	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 632,015	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:				\$			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.	<u>/2003</u>	\$ _____
13.	<u>/2004</u>	\$ _____
14.	<u>/2005</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.  
 This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
 by the length of the lease \_\_\_\_\_.

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

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

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ 12,221 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

XIII. EXPENSES RELATING TO 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 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. CLASSROOM PORTION: _____</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. CLINICAL PORTION: _____</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)		200		200
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	200	\$	200
10	SUM OF line 9, col. 1 and 2 (e)	\$	200		

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	

- (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/3	hrs	\$		\$ 10,238	\$	\$	10,238	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			2,453			2,453	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			21,823	98		21,921	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescripts				200,763		200,763	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				4,052			4,052	13
14	TOTAL			\$		\$ 38,566	\$ 200,861	\$	\$ 239,427	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 &amp; ID Number Heritage Manor East-Beardstown

# 0041632

Report Period Beginning: 1/01/2002

Ending:

12/31/2002

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(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	\$ 5,632	\$	1
2 Cash-Patient Deposits	10,227		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	266,513		3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	13,553		6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	(1,547,386)		8
9 Other(specify):			9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (1,251,461)	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	40,000		13
14 Buildings, at Historical Cost	2,286,224		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	231,318		16
17 Accumulated Depreciation (book methods)	(632,015)		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): <u>Deferred Tax Asset</u>			23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,925,527	\$	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 674,066	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 37,144	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	10,227		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	78,161		30
31 Accrued Taxes Payable (excluding real estate taxes)	2,561		31
32 Accrued Real Estate Taxes(Sch.IX-B)	22,984		32
33 Accrued Interest Payable	148		33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 <u>Security Deposits</u>	9,798		36
37			37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 161,023	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable	1,255,526		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>	\$ 1,255,526	\$	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,416,549	\$	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ (742,483)	\$	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 674,066	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (818,174)	1
2	Restatements (describe):		2
3	<u>Audit Adjustment</u>	(9,999)	3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (828,173)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	85,690	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 85,690	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (742,483)	24 *

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

Facility Name &amp; ID Number Heritage Manor East-Beardstown

# 0041632

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

**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	\$ 1,961,296	1
2	Discounts and Allowances for all Levels	(221,143)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,740,153	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	89,303	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 89,303	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	942	12
13	Barber and Beauty Care	244	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	105,324	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,545	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 108,055	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	101	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 101	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,937,612	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	358,511	31
32	Health Care	830,780	32
33	General Administration	454,424	33
<b>B. Capital Expense</b>			
34	Ownership	208,207	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37	Loss from Non-Nursing property		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,851,922	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	85,690	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 85,690	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 &amp; ID Number Heritage Manor East-Beardstown

# 0041632

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

## 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	1,848	\$ 39,583	\$ 19.14	1
2	Assistant Director of Nursing		0		2
3	Registered Nurses	3,678	79,161	20.72	3
4	Licensed Practical Nurses	11,099	159,853	13.62	4
5	Nurse Aides & Orderlies	35,894	335,156	8.79	5
6	Nurse Aide Trainees	25	200	8.00	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	986	12,811	12.25	8
9	Activity Director				9
10	Activity Assistants	2,934	25,206	8.02	10
11	Social Service Workers	690	8,476	12.28	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	12,397	100,266	7.65	15
16	Dishwashers				16
17	Maintenance Workers	1,730	21,732	11.32	17
18	Housekeepers	7,547	50,309	6.42	18
19	Laundry	2,007	20,937	9.61	19
20	Administrator	2,080	46,215	22.22	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	4,064	44,960	9.84	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	86,979	\$ 944,865 *	\$ 10.23	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
35	Dietary Consultant	\$ 0	35
36	Medical Director	0	36
37	Medical Records Consultant	940	37
38	Nurse Consultant		38
39	Pharmacist Consultant	2,214	39
40	Physical Therapy Consultant		40
41	Occupational Therapy Consultant		41
42	Respiratory Therapy Consultant		42
43	Speech Therapy Consultant		43
44	Activity Consultant		44
45	Social Service Consultant	3,065	45
46	Other(specify)		46
47			47
48			48
49	TOTAL (lines 35 - 48)	\$ 6,219	49

## C. CONTRACT NURSES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference
50	Registered Nurses	\$ 959	50
51	Licensed Practical Nurses	33,671	51
52	Nurse Aides	143	52
53	TOTAL (lines 50 - 52)	\$ 34,773	53





Facility Name & ID Number Heritage Manor East-Beardstown# 0041632Report Period Beginning: 1/01/2002Ending: 12/31/2002**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO no If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 38,873  
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. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 2,011
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_
- c. What percent of all travel expense relates to transportation of nurses and patients? 100
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
- g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Sulaski & Webb The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available at this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.

