

		FOR OHF USE				

LL1

**2003  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0002923</u></p> <p><b>Facility Name:</b> <u>Heartland Manor Nursing Center</u></p> <p><b>Address:</b> <u>410 N. W. Third St.</u> <u>Casey</u> <u>62420</u> Number City Zip Code</p> <p><b>County:</b> <u>Clark</u></p> <p><b>Telephone Number:</b> <u>(217) 932-4081</u> Fax # <u>(217) 932-4922</u></p> <p><b>IDPA ID Number:</b> <u>370860567001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>12/18/64</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501(c)(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b> Name: <u>Michael W. Martin</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/02</u> to <u>06/30/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Type or Print Name) _____</td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> <td>(Date) _____</td> </tr> <tr> <td colspan="2">(Print Name and Title) _____</td> </tr> <tr> <td colspan="2">(Firm Name &amp; Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td colspan="2">(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____			(Title) _____		Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																								
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																								
<b>IRS Exemption Code</b> <u>501(c)(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																								
	<input type="checkbox"/> "Sub-S" Corp.	_____																																								
	<input type="checkbox"/> Limited Liability Co.	_____																																								
	<input type="checkbox"/> Trust	_____																																								
	<input type="checkbox"/> Other	_____																																								
Officer or Administrator of Provider	(Signed) _____	(Date) _____																																								
	(Type or Print Name) _____																																									
	(Title) _____																																									
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____																																								
	(Print Name and Title) _____																																									
	(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>																																									
	(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>																																									

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

# 0002923 Report Period Beginning: 07/01/02 Ending: 06/30/03

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 N/A

	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	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Public Aid Recipient	3 Private Pay	4 Other	5 Total	
		8	SNF	1,438	265	
9	SNF/PED					9
10	ICF	11,877	8,742		20,619	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,315	9,007	1,744	24,066	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.60%

D. How many bed-hold days during this year were paid by Public Aid? None (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)

Meals on Wheels

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  Non-allowable costs have been eliminated in Schedule V, Column 7

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 12/18/1964

J. Was the facility purchased or leased after January 1, 1978?  
 YES  Date N/A NO

K. Was the facility certified for Medicare during the reporting year?  
 YES  NO  If YES, enter number of beds certified 28 and days of care provided 1,744

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/03 Fiscal Year: 06/30/03

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

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/02 Ending: 06/30/03

**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	218,791	12,527	5,850	237,168		237,168	237,168			1
2	Food Purchase		109,240		109,240		109,240	(12,477)	96,763		2
3	Housekeeping	76,243	21,320	191	97,754		97,754	(18,600)	79,154		3
4	Laundry	86,496	13,138	219	99,853		99,853		99,853		4
5	Heat and Other Utilities			81,152	81,152		81,152		81,152		5
6	Maintenance	39,762	4,674	55,483	99,919		99,919	(1,972)	97,947		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	421,292	160,899	142,895	725,086		725,086	(33,049)	692,037		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,375	6,375		6,375		6,375		9
10	Nursing and Medical Records	1,013,110	61,225	9,878	1,084,213		1,084,213		1,084,213		10
10a	Therapy		22,959	142,778	165,737		165,737		165,737		10a
11	Activities	50,033		5,423	55,456		55,456		55,456		11
12	Social Services	20,994		2,124	23,118		23,118		23,118		12
13	Nurse Aide Training			1,750	1,750		1,750		1,750		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,084,137	84,184	168,328	1,336,649		1,336,649		1,336,649		16
	<b>C. General Administration</b>										
17	Administrative	76,249			76,249		76,249		76,249		17
18	Directors Fees										18
19	Professional Services			62,594	62,594		62,594	(7,115)	55,479		19
20	Dues, Fees, Subscriptions & Promotions			9,531	9,531		9,531	(405)	9,126		20
21	Clerical & General Office Expenses	97,914	8,340	8,834	115,088		115,088		115,088		21
22	Employee Benefits & Payroll Taxes			321,492	321,492		321,492		321,492		22
23	Inservice Training & Education			354	354		354		354		23
24	Travel and Seminar			5,881	5,881		5,881		5,881		24
25	Other Admin. Staff Transportation			936	936		936		936		25
26	Insurance-Prop.Liab.Malpractice			55,650	55,650		55,650		55,650		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	174,163	8,340	465,272	647,775		647,775	(7,520)	640,255		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,679,592	253,423	776,495	2,709,510		2,709,510	(40,569)	2,668,941		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

\*\* See schedule of adjustments attached at end of cost report.

Facility Name &amp; ID Number

Heartland Manor Nursing Center

#0002923

Report Period Beginning:

07/01/02

Ending:

06/30/03

## 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			88,672	88,672		88,672	(2,635)	86,037			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,946	6,946		6,946	(466)	6,480			32
33	Real Estate Taxes			3,334	3,334		3,334	(3,334)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			98,952	98,952		98,952	(6,435)	92,517			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	22,005	73,175	1,994	97,174		97,174		97,174			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* <b>Nonallowable Costs</b>			16,335	16,335		16,335	(16,848)	(513)			43
44	<b>TOTAL Special Cost Centers</b>	22,005	73,175	72,532	167,712		167,712	(16,848)	150,864			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,701,597	326,598	947,979	2,976,174		2,976,174	(63,852)	2,912,322			45

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

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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	(12,477)	2		4
5 Telephone, TV & Radio in Resident Rooms	(1,065)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(2,635)	30		9
10 Interest and Other Investment Income	(231)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(2,400)	43		18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers	(7,115)	19		22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(11,060)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(199)	43		28
29 Other-Attach Schedule See attached PG5A	(26,670)	var		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (63,852)		\$	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)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (63,852)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Heartland Manor Nursing Center

ID# 0002923

Report Period Beginning: 07/01/02

Ending: 06/30/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Finance charges & late fees	\$ (235)	32	1
2	Chamber of Commerce & Rotary dues	(405)	20	2
3	Repair of non-care asset (rental property)	(1,972)	6	3
4	Offset cleaning income from non-care asset			4
5	against related cost	(18,600)	3	5
6	Disallow real estate tax on non-care asset	(3,334)	33	6
7	Disallow ancillary Medicare costs	(1,966)	43	7
8	Resident personal expenses	(158)	43	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>	(26,670)		49

See Accountants' Compilation Report

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heartland Manor Nursing Center

# 0002923

Report Period Beginning:

07/01/02

Ending:

06/30/03

## 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	(12,477)	0	0	0	0	0	0	0	0	0	0	(12,477)	2
3	Housekeeping	(18,600)	0	0	0	0	0	0	0	0	0	0	(18,600)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,972)	0	0	0	0	0	0	0	0	0	0	(1,972)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(33,049)</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>(33,049)</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	(7,115)	0	0	0	0	0	0	0	0	0	0	(7,115)	19
20	Fees, Subscriptions & Promotions	(405)	0	0	0	0	0	0	0	0	0	0	(405)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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>(7,520)</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>(7,520)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(40,569)</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>(40,569)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/02 Ending: 06/30/03

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	(2,635)	0	0	0	0	0	0	0	0	0	0	(2,635) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(466)	0	0	0	0	0	0	0	0	0	0	(466) 32
33	Real Estate Taxes	(3,334)	0	0	0	0	0	0	0	0	0	0	(3,334) 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>(6,435)</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>(6,435) 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):*	(16,848)	0	0	0	0	0	0	0	0	0	0	(16,848) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(16,848)</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>(16,848) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(63,852)</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>(63,852) 45</b>

Facility Name & ID Number **Heartland Manor Nursing Center**

# **0002923**

Report Period Beginning: **07/01/02**

Ending: **06/30/03**

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule		N/A		N/A		

**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		\$			\$	\$	1
2	V	N/A						2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number      Heartland Manor Nursing Center      #      0002923      Report Period Beginning:      07/01/02      Ending:      06/30/03

## 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									\$	1
2	N/A									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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/02 Ending: 06/30/03

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 N/A  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8	N/A								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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/02 Ending: 06/30/03

## 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	
						Original	Balance					
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											
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	Union Planters Bank	X	New wing	\$4,545.00	12/1996	\$ 510,000		01/2016	0.0775	\$ 804	1	
2											2	
3	Leasehold obligation	X	Dishwasher	\$59.00	6/1999	2,420	874	5/2004	0.1612	206	3	
4	Leasehold obligation	X	Electric beds	\$1,277.00	3/2001	38,225	8,606	3/2004	0.1204	1,842	4	
5	Leasehold obligation	X	Time clock	\$132.00	12/2002	6,915	6,141	11/2007	0.0382	135	5	
<b>Working Capital</b>												
6	Union Planters Bank	X		none	2/2002	200,000		demand	0.0475	3,724	6	
7											7	
8	Various vendors	X	Finance charges & late fees						various	235	8	
9	TOTAL Facility Related			\$6,013.00		\$ 757,560	\$ 15,621			\$ 6,946	9	
<b>B. Non-Facility Related*</b>												
10									Less: Nonallowable finance charges	(235)	10	
11									Offset of interest income	(231)	11	
12											12	
13											13	
14	TOTAL Non-Facility Related					\$	\$			\$ (466)	14	
15	TOTALS (line 9+line14)					\$ 757,560	\$ 15,621			\$ 6,480	15	

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

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

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



**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 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 2003 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,

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heartland Manor Nursing Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0002923

CONTACT PERSON REGARDING THIS REPORT David J. Sauer

TELEPHONE 217-932-4081 FAX #: 217-932-4922

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

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(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>Facility pays real estate taxes</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
2. <u>on non-care assets. All costs</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
3. <u>are adjusted out of the cost report</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
4. <u>_____</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
5. <u>03-11-19-08-203-046</u>	<u>Lots 8 &amp; 9 Sturdevant &amp; Gobel Addn</u>	\$ <u>1,028.10</u>	\$ <u>None</u>
6. <u>03-11-19-08-203-047</u>	<u>Lots 4 &amp; 5 Sturdevant &amp; Gobel Addn</u>	\$ <u>1,133.82</u>	\$ <u>None</u>
7. <u>03-11-19-08-203-049</u>	<u>Lot 2 Sturdevant &amp; Gobel Addn</u>	\$ <u>1,237.06</u>	\$ <u>None</u>
8. <u>NOTE: Attached real estate bills ar for 2002 taxes payable in 2003.</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
9. <u>As a 6/30 year end facility payment included on this cost report is for</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
10. <u>2001 taxes paid in calendar 2002.</u>	<u>_____</u>	\$ <u>_____</u>	\$ <u>_____</u>
<b>TOTALS</b>		\$ <u>3,398.98</u>	\$ <u>None</u>

**B. Real Estate Tax Cost Allocation:**

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

See Accountants' Compilation Report

A. Square Feet: 31,047 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

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 ground: (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)

None

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

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

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>Resident care</u>	<u>152,472</u>	<u>1964</u>	<u>\$ 24,000</u>	1
2					2
3	<b>TOTALS</b>	<u>152,472</u>		<u>\$ 24,000</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center

# 0002923

Report Period Beginning:

07/01/02

Ending:

06/30/03

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	78	1964	1964	\$ 385,838	\$	25	\$	\$	\$ 385,838	4
5		1966	1966	19,502		25			19,502	5
6		1970	1970	3,400		25			3,400	6
7		1972	1972	11,798		25			11,798	7
8	21	1996	1996	828,949	20,724	40	20,724		145,069	8
<b>Improvement Type**</b>										
9	Building improvements		1973	7,123		10			7,123	9
10	Building improvements		1974	28,947	910	14-30	910		28,021	10
11	Building improvements		1975	7,064		10-30			7,064	11
12	Building improvements		1976	1,607	28	10-30	28		1,438	12
13	Building improvements		1977	1,808		7			1,808	13
14	Building improvements		1978	6,161		5-15			6,161	14
15	Building improvements		1979	3,730		10			3,730	15
16	Building improvements		1980	8,894		7			8,894	16
17	Building improvements		1981	1,376		7			1,376	17
18	Building improvements		1982	12,298		3-30			12,298	18
19	Building improvements		1983	6,263		5			6,263	19
20	Building improvements		1984	18,714		5-15			18,714	20
21	Building improvements		1985	8,044		5-15			8,044	21
22	Building improvements		1986	45,792	4,580	10-20	4,580		44,304	22
23	Building improvements		1987	28,030		5-15			28,030	23
24	Building improvements		1988	5,444	363	12-15	363		5,444	24
25	Building improvements		1989	3,775	182	15	182		3,457	25
26	Building improvements		1990	3,742		7			3,742	26
27	Building improvements (less disposition of \$2,795 in 2002-03)		1991	3,585		10			3,585	27
28	Heating/air system		1992	80,277	4,014	20	4,014		48,836	28
29	Building improvements		1992	3,084		10			3,084	29
30	Building improvements		1992	2,168		10			2,168	30
31	Wallpaper		1992	308		10			308	31
32	Building improvements		1992	647		10			647	32
33	Building improvements		1992	4,263	284	15	284		3,055	33
34	Ceiling/floor		1992	49,925	2,498	20	2,498		25,901	34
35	Sprinkler system		1992	60,121	3,006	20	3,006		32,065	35
36	Storage shelving		1993	4,090	239	10	239		4,090	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Heartland Manor Nursing Center

# 0002923

Report Period Beginning:

07/01/02

Ending:

06/30/03

## 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	Storage shelving	1993	\$ 1,003	\$ 50	10	\$ 50	\$	\$ 1,003	37
38	Resident security system	1993	3,909	195	20	195		2,036	38
39	Cabinets	1993	42,611	2,311	15-20	2,311		21,871	39
40	Heating/air/tubs	1993	29,226	1,444	20	1,444		13,900	40
41	Fire alarm system	1993	12,350	618	20	618		7,359	41
42	Plumbing and water system	1993	8,684	434	20	434		4,450	42
43	Cubicle tracking	1993	1,768	177	10	177		1,812	43
44	Building improvements	1994	10,493	517	20	517		4,511	44
45	Building improvements	1995	24,889	2,053	10-20	2,053		14,649	45
46									46
47	Architect fees	1996	74,806	1,872	40	1,872		13,576	47
48	Hvac/insulation/ducts	1996	30,292	759	40	759		4,809	48
49	Sprinklers	1996	9,774	183	40	183		1,525	49
50	Painting	1996	4,052	76	40	76		494	50
51	General contractor fees	1996	7,841	147	40	147		1,225	51
52	Electrical	1996	18,390	460	40	460		2,547	52
53	Chapel work - New Hutton	1996	12,572	629	40	629		4,296	53
54	Cubicle curtain tracking	1996	742	37	20	37		266	54
55	Room signs	1996	3,331	167	20	167		1,166	55
56	Emergency lighting Jones wing	1996	142	7	20	7		53	56
57	Bath systems Jones wing	1996	8,610	431	20	431		3,014	57
58	Sprinklers Jones wing	1996	340	34	10	34		238	58
59	Security locks Jones wing	1996	1,049	52	20	52		367	59
60	Carpeting Jones wing (disposed of 12/31/02)	1996							60
61	Call lights Jones wing	1996	1,881	94	11	94		658	61
62	Air filtration Jones wing	1996	2,081	104	20	104		728	62
63	Wiring-computers & phone	1996	2,970		5			2,970	63
64	Hallway support bars	1996	750	75	10	75		519	64
65	Capitalized interest-new wing	1996	4,700	118	40	118		823	65
66	Plumbing	1996	4,640	232	20	232		1,733	66
67	Electrical work	1996	4,662	234	20	234		1,657	67
68	Flooring	1996	2,400	120	20	120		820	68
69	Courtyard	1996	2,766	138	20	138		956	69
70	TOTAL (lines 4 thru 69)		\$ 1,990,491	\$ 50,596		\$ 50,596	\$	\$ 1,001,288	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Heartland Manor Nursing Center

# 0002923

Report Period Beginning:

07/01/02

Ending:

06/30/03

## 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		\$ 1,990,491	\$ 50,596		\$ 50,596	\$	\$ 1,001,288	1
2	Concrete work entrance	1996	1,470	74	74	74		503	2
3	Building appraisal	1997	2,578	64	64	64		424	3
4	Chapel HVAC	1997	2,324	116	116	116		758	4
5	Stained glass window	1997	2,052	103	103	103		642	5
6	Steel door	1997	422	21	21	21		130	6
7	Hot water heater - North Wing	1997	3,838	192	192	192		1,200	7
8	Hot water heater - Laundry	1997	2,893	145	145	145		880	8
9	Hand rails	1997	5,252	263	263	263		1,576	9
10	Painting	1997	478	24	24	24		142	10
11	Walk in cooler	1997	11,524	576	576	576		3,409	11
12	Fire system work	1997	513	26	26	26		150	12
13	Key pad - security system	1997	360	18	18	18		105	13
14	Hot water heater - Kitchen	1997	3,508	175	175	175		1,008	14
15	Tile flooring - Lobby	1997	900	45	45	45		259	15
16	Hot water heater	1998	7,318	366	366	366		2,013	16
17	Bed light installation	1998	1,826	91	91	91		487	17
18	Hand rails	1998	1,413	71	71	71		374	18
19	Sprinklers	1998	708	35	35	35		186	19
20	Generator bypass switch	1998	1,567	78	78	78		405	20
21									21
22	Lighting - kitchen	1998	985	49	49	49		250	22
23	Paging system	1998	516	26	26	26		127	23
24	Room divider remodeling	1998	391	20	20	20		97	24
25	Bathroom lighting	1998	1,090	55	55	55		264	25
26	South wing remodeling	1998	165	8	8	8		39	26
27	Roof over generator room	1998	568	28	28	28		137	27
28	Bathrooms	1998	7,394	370	370	370		1,756	28
29	Bathrooms-South & Hutton	1998	6,197	310	310	310		1,421	29
30	Fire Alarm System	1999	1,317	66	66	66		280	30
31	Fire & Smoke Dampers	1999	1,664	83	83	83		340	31
32		1999	1,760	88	88	88		367	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,063,482	\$ 54,182		\$ 54,182	\$	\$ 1,021,017	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Heartland Manor Nursing Center

# 0002923

Report Period Beginning:

07/01/02

Ending:

06/30/03

## 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		\$ 2,063,482	\$ 54,182		\$ 54,182		\$ 1,021,017	1
2	Generator panel	2000	2,023	202	10	202		725	2
3	Gazebo	2000	2,733	273	10	273		683	3
4	Anti-scald valves (2)	2001	655	65	10	65		163	4
5	Shower floor replacement	2001	500	25	20	25		63	5
6	Dining room lights	2001	6,013	301	20	301		752	6
7									7
8	Toilet stools & seats	2001	1,414	141	10	141		266	8
9	Parking lot asphalt reseal	2001	5,032	251	20	251		440	9
10	Ceramic wall tile	2001	365	18	20	18		32	10
11	Washer & nurse call	2001	485	48	10	48		76	11
12	Bath fans	2001	150	15	10	15		24	12
13	Extend legs on links	2001	607	61	10	61		96	13
14	Wallpaper front lobby	2001	150	15	10	15		26	14
15	Remodel North & South showers	2002	2,332	116	20	116		145	15
16	Dorma 7605 EMF-T pullside fire door closers	2002	912	91	10	91		114	16
17	Water heater	2002	4,165	208	20	208		225	17
18									18
19	Compressor - freezer	2002	810	74	10	74		74	19
20	Compressor - kitchen air conditioner	2002	805	40	15	40		40	20
21	Carpet	2003	2,887	18	20	18		18	21
22	Bypass switch for generator	2003	2,166	108	50	108		108	22
23	Sign	2003	850	28	10	28		28	23
24									24
25									25
26									26
27	Reconciling items								27
28	Variance in IDPA records & cost report - 1992		26,230						28
29	Variance in IDPA records & cost report - 1993		(22,330)						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,102,436	\$ 56,280		\$ 56,280		\$ 1,025,115	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	\$ 468,153	\$ 28,232	\$ 28,232	\$	5-15	\$ 308,045	71
72	Current Year Purchases	21,932	1,525	1,525		5-15	1,525	72
73	Fully Depreciated Assets	92,616					92,646	73
74								74
75	TOTALS	\$ 582,701	\$ 29,757	\$ 29,757	\$		\$ 402,216	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	Resident care	1994 Ford van	1995	\$ 41,610	\$	\$	\$	5	\$ 41,610	76
77										77
78										78
79										79
80	TOTALS			\$ 41,610	\$	\$	\$		\$ 41,610	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,750,747	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 86,037	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 86,037	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)	\$ 1,468,941	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	Aklinski building - 1994	\$ 40,045	\$	\$ 8,984	86
87	Aklinski concrete work-1994	3,900	1,027	1,300	87
88	Delaware house - 1996	17,550	195	2,363	88
89	Land- 1994, 1998, 2002	30,000	963		89
90	Repp house - 1998	38,500	450	2,527	90
91	TOTALS	\$ 129,995	\$ 2,635	\$ 15,174	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: N/A  
 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			<u>N/A</u>			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>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</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: \$ N/A Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

\* 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.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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 checked="" 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 checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>40</u></p>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

	Facility			
	1 Drop-outs	2 Completed	3 Contract	4 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	250	1,500		1,750
8 Nurse Aide Competency Tests				
9 TOTALS	\$ 250	\$ 1,500	\$	\$ 1,750
10 SUM OF line 9, col. 1 and 2 (e)	\$ 1,750			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>14</b>

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)			
			Staff		Outside Practitioner (other than consultant)		Units	Cost								
			Units of Service	Cost	Units	Cost										
1	Licensed Occupational Therapist	10A (2), (3)	hrs	\$	3,033	\$	45,502	\$	9,578		3,033	\$	55,080	1		
2	Licensed Speech and Language Development Therapist	10A (3)	hrs		1,348		20,214				1,348		20,214	2		
3	Licensed Recreational Therapist		hrs											3		
4	Licensed Physical Therapist	10A (3)	hrs		5,137		77,062				5,137		77,062	4		
5	Physician Care		visits											5		
6	Dental Care		visits											6		
7	Work Related Program		hrs											7		
8	Habilitation		hrs											8		
9	Pharmacy	39(2)	# of prescripts						66,946				66,946	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10		
11	Academic Education		hrs											11		
12	Exceptional Care Program	39(1), (2)	2445		22,005				6,229		2,445		28,234	12		
13	Other (specify): <a href="#">See attached</a>	various			399		1,994		13,381		399		15,375	13		
14	TOTAL			\$	22,005		9,917	\$	144,772	\$	96,134		12,362	\$	262,911	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**Heartland Manor Nursing Center**

**Provider #: 0002923**

**07/01/02 to 06/30/03**

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

<u>Service</u>	<u>Line (column) Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
Oxygen	39(3)	399	1,994	
Respiratory Therapy	10A(2)			13,381
Total			<u>1,994</u>	<u>13,381</u>

**See Accountants' Compilation Report**

STATE OF ILLINOIS

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/02 Ending: 06/30/03  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/03 (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	\$ 51,537	\$ 51,537	1
2	Cash-Patient Deposits	7,493	7,493	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,000 )	365,867	365,867	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,983	74,983	6
7	Other Prepaid Expenses	32,573	32,573	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>	\$ 532,453	\$ 532,453	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,151	20,151	12
13	Land	54,000	24,000	13
14	Buildings, at Historical Cost	2,171,193	2,102,436	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	607,971	624,311	16
17	Accumulated Depreciation (book methods)	(1,436,135)	(1,468,941)	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 (spt Security Deposit)	372	372	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,417,552	\$ 1,302,329	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,950,005	\$ 1,834,782	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 149,056	\$ 149,056	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,492	7,492	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,137	123,137	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,704	4,704	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37	Employee Annuity	1,272	1,272	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 285,661	\$ 285,661	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	Lease Obligations	15,621	15,621	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 15,621	\$ 15,621	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 301,282	\$ 301,282	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,648,723	\$ 1,533,500	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,950,005	\$ 1,834,782	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,624,158	1
2	Restatements (describe):		2
3			3
4	Adjustments subsequent to cost report preparation	3,009	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,627,167	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	21,555	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) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 21,556	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,648,723	24 *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Facility Name &amp; ID Number Heartland Manor Nursing Center

# 0002923

Report Period Beginning: 07/01/02

Ending:

Page 19

06/30/03

**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	\$ 2,662,127	1
2	Discounts and Allowances for all Levels	(99,252)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,562,875	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	198,414	6
7	Oxygen	41,141	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 239,555	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		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	12,477	14
15	Telephone, Television and Radio	1,866	15
16	Rental of Facility Space	8,863	16
17	Sale of Drugs	41,021	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40	19
20	Radiology and X-Ray		20
21	Other Medical Services	104,586	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 168,853	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	7,197	24
25	Interest and Other Investment Income***	231	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,428	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See attached PG19A</u>	19,018	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 19,018	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,997,729	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	725,086	31
32	Health Care	1,336,649	32
33	General Administration	647,775	33
<b>B. Capital Expense</b>			
34	Ownership	98,952	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	113,509	35
36	Provider Participation Fee	54,203	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,976,174	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	21,555	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 21,555	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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. SEE ACCOUNTANTS' COMPILATION REPORT

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

Heartland Manor Nursing Center  
Facility ID# 00002923  
07/01/02 - 06/30/03

Schedule XVII (A) - Line 28: Other Revenue

Vending income	961
Oil income	226
Cleaning income	18,600
Miscellaneous income	481
Gain/loss on sale of assets	(1,959)
Lab/Physicals	12
Shirts & jackets	<u>698</u>
Total - Line 28	<u><u>19,019</u></u>

Facility Name & ID Number Heartland Manor Nursing Center

# 0002923

Report Period Beginning: 07/01/02

Ending:

06/30/03

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	1,952	2,080	\$ 44,617	\$ 21.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,253	12,916	223,609	17.31	3
4	Licensed Practical Nurses	15,235	18,087	256,470	14.18	4
5	Nurse Aides & Orderlies	49,715	54,851	510,419	9.31	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	700	818	6,857	8.38	9
10	Activity Assistants	5,077	5,523	43,176	7.82	10
11	Social Service Workers	1,842	2,182	20,994	9.62	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,120	24,462	11.54	13
14	Head Cook	5,859	6,061	46,238	7.63	14
15	Cook Helpers/Assistants	14,606	15,886	131,757	8.29	15
16	Dishwashers	2,775	2,823	16,334	5.79	16
17	Maintenance Workers	2,374	3,005	39,762	13.23	17
18	Housekeepers	12,139	12,796	76,243	5.96	18
19	Laundry	10,235	10,500	86,496	8.24	19
20	Administrator	1,956	2,080	76,249	36.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,583	8,216	97,914	11.92	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)	145,301	159,944	\$ 1,701,597 *	\$ 10.64	34

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	124	\$ 5,011	1(3)	35
36	Medical Director	26	6,375	9(3)	36
37	Medical Records Consultant	16	1,500	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,020	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,124	11(3)	44
45	Social Service Consultant	48	2,124	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	262	\$ 18,154		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	31	899	10(3)	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	31	\$ 899		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

\*\* See instructions.



**Heartland Manor Nursing Center**

**Provider #: 0002923**

**07/01/02 to 06/30/03**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

Total (agree to Schedule V, line 19, column 3)	62,594
Less: Non-allowable acquisition costs	(434)
Out-of-period legal expenses	(6,681)
Total (agree to Schedule V, line 19, column 8)	<u>55,479</u>

**See Accountants' Compilation Report**

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY2000	6 FY2001	7 FY2002	8 FY2003	9 FY2004	10 FY2005	11 FY2006	12 FY2007	13 FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6			N/A										
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center# 0002923Report Period Beginning: 07/01/02Ending: 06/30/03**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Health Care Association - 5,332
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,806 Line 10(2)
- (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. N/A
- (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 NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,203  
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 12,477
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation. N/A
- 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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- 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? 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. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Larsson, Woodyard & Henson 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. Audit still in process
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

RECONCILIATION REPORT

Heartland Manor Nursin 12:04 PM 11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-63,852	equal to	-63,852	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	6,480	equal to	6,480	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	86,037	equal to	86,037	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	1,750	equal to	1,750	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	22,005	equal to	22,005	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	152,356	equal to	165,737	-13,381	FAILED	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8:2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	96,134	equal to	96,134	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	725,086	equal to	725,086	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,336,649	equal to	1,336,649	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	647,775	equal to	647,775	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	98,952	equal to	98,952	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	113,509	equal to	113,509	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38b41+43	4
Income Stat. Prov. Partic.	54,203	equal to	54,203	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,035,115	equal to	1,013,110	22,005	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	22,005	-22,005	FAILED	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	50,033	equal to	50,033	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	20,994	equal to	20,994	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	218,791	equal to	218,791	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	39,762	equal to	39,762	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	76,243	equal to	76,243	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	86,496	equal to	86,496	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	76,249	equal to	76,249	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	97,914	equal to	97,914	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,701,597	equal to	1,701,597	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,011	< or = to	5,850	-839	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,375	< or = to	6,375	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,419	< or = to	9,878	-6,459	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,124	< or = to	5,423	-3,299	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,124	< or = to	2,124	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	76,249	equal to	76,249	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	0	equal to	0	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	62,594	equal to	62,594	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	321,492	equal to	321,492	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	9,126	equal to	9,126	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5,881	equal to	5,881	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	54,203	equal to	54,203	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,744	equal to	1,744	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	0	equal to	0	0	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4†	B.	14	8
Total loan balance	15,621	equal to	0	15,621	FAILED	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	24,000	equal to	24,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,102,436	equal to	2,102,436	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	624,311	equal to	624,311	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,468,941	equal to	1,468,941	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,648,723	equal to	1,648,723	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	21,555	equal to	21,555	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,950,005	equal to	1,950,005	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1





	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	218,791	12,527	5,850	237,168	0	237,168	0	237,168
2. Food Purchase	0	109,240	0	109,240	0	109,240	-12,477	96,763
3. Housekeeping	76,243	21,320	191	97,754	0	97,754	-18,600	79,154
4. Laundry	86,496	13,138	219	99,853	0	99,853	0	99,853
5. Heat and Other Utilities	0	0	81,152	81,152	0	81,152	0	81,152
6. Maintenance	39,762	4,674	55,483	99,919	0	99,919	-1,972	97,947
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	421,292	160,899	142,895	725,086	0	725,086	-33,049	692,037
9. Medical Director	0	0	6,375	6,375	0	6,375	0	6,375
10. Nursing & Medical Records	1,013,110	61,225	9,878	1,084,213	0	1,084,213	0	1,084,213
10a. Therapy	0	22,959	142,778	165,737	0	165,737	0	165,737
11. Activities	50,033	0	5,423	55,456	0	55,456	0	55,456
12. Social Services	20,994	0	2,124	23,118	0	23,118	0	23,118
13. Nurse Aide Training	0	0	1,750	1,750	0	1,750	0	1,750
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,084,137	84,184	168,328	1,336,649	0	1,336,649	0	1,336,649
17. Administrative	76,249	0	0	76,249	0	76,249	0	76,249
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	62,594	62,594	0	62,594	-7,115	55,479
20. Fees, Subscriptions & Promotion	0	0	9,531	9,531	0	9,531	-405	9,126
21. Clerical & General Office	97,914	8,340	8,834	115,088	0	115,088	0	115,088
22. Employee Benefits & Payroll	0	0	321,492	321,492	0	321,492	0	321,492
23. Inservice Training & Education	0	0	354	354	0	354	0	354
24. Travel and Seminar	0	0	5,881	5,881	0	5,881	0	5,881
25. Other Admin. Staff Trans	0	0	936	936	0	936	0	936
26. Insurance-Prop.Liab.Malpractice	0	0	55,650	55,650	0	55,650	0	55,650
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	174,163	8,340	465,272	647,775	0	647,775	-7,520	640,255
29. Total General Administrative	1,679,592	253,423	776,495	2,709,510	0	2,709,510	-40,569	2,668,941
30. Depreciation	0	0	88,672	88,672	0	88,672	-2,635	86,037
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	6,946	6,946	0	6,946	-466	6,480
33. Real Estate	0	0	3,334	3,334	0	3,334	-3,334	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	98,952	98,952	0	98,952	-6,435	92,517
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	22,005	73,175	1,994	97,174	0	97,174	0	97,174
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	54,203	54,203	0	54,203	0	54,203
43. Other (specify):*	0	0	16,335	16,335	0	16,335	-16,848	-513
44. Total Special Cost Ce	22,005	73,175	72,532	167,712	0	167,712	-16,848	150,864
45. Grand Total	1,701,597	326,598	947,979	2,976,174	0	2,976,174	-63,852	2,912,322

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	51,537	51,537
2. Cash - Patient Deposits	7,493	7,493
3. Accounts & Notes Recievable	365,867	365,867
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	74,983	74,983
7. Other Prepaid Expenses	32,573	32,573
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	532,453	532,453
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	20,151	20,151
13. Land	54,000	24,000
14. Buildings, at Historical Cost	2,171,193	2,102,436
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	607,971	624,311
17. Accumulated Depreciation (book methods)	-1,436,135	-1,468,941
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	372	372
23. other (specify):	0	0
24. Total Long-Term Assets	1,417,552	1,302,329
25. Total Assets	1,950,005	1,834,782
CURRENT LIABILITIES		
26. Accounts Payable	149,056	149,056
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	7,492	7,492
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	123,137	123,137
31. Accrued Taxes Payable	4,704	4,704
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	1,272	1,272
38. Total Current Liabilities	285,661	285,661
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	15,621	15,621
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	15,621	15,621
46. Total Liabilities	301,282	301,282
47. Total Equity	1,648,723	1,533,500
48. Total Liabilities and Equity	1,950,005	1,834,782

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,662,127
2. Discounts and Allowances for all Levels	-99,252
Subtotal - Inpatient Care	2,562,875
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	198,414
7. Oxygen	41,141
Subtotal - Ancillary Revenue	239,555
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	12,477
15. Telephone, Television, and Radio	1,866
16. Rental of Facility Space	8,863
17. Sale of Drugs	41,021
18. Sale of Supplies to Non-Patients	0
19. Laboratory	40
20. Radiology and X-Ray	0
21. Other Medical Services	104,586
22. Laundry	0
Subtotal - Other Operating Revenue	168,853
24. Contributions	7,197
25. Interest and Other Investments Income	231
Subtotal - Non-Operating Revenue	7,428
27. Other Revenue (specify):	19,018
28. Other Revenue (specify):	0
Subtotal - Other Revenue	19,018
30. Total Revenue	2,997,729
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	248,113
42. Income Taxes	0
43. Net Income or Loss for the Year	248,113

Page

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23 Provider Participation fee is linked from page 4