

		FOR OHF USE				

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**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>0042705</u></p> <p><b>Facility Name:</b> <u>Heritage Manor South-Beardstown</u></p> <p><b>Address:</b> <u>RT. 3 P.O. BOX 446</u> <u>Beardstown</u> <u>61938</u>        Number City Zip Code</p> <p><b>County:</b> <u>Cass</u></p> <p><b>Telephone Number:</b> <u>( 217 ) 323-4055</u> Fax # ( )</p> <p><b>IDPA ID Number:</b> <u>370909086022</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>06/30/97</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input 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> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" 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>  <b>Name:</b> <u>CRAIG L. ATER</u> <b>Telephone Number:</b> <u>( 309 ) 823-7135</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input 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> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" 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>01/01/2003</u> to <u>12/31/2003</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 data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 747">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1144 747 1281 828"></td> <td data-bbox="1281 747 1921 803">(Type or Print Name) <u>Craig L. Ater</u></td> </tr> <tr> <td data-bbox="1144 803 1281 828"></td> <td data-bbox="1281 803 1921 828">(Title) <u>Senior V.P. &amp; CFO</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 1039">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) _____ Fax # ( ) _____</td> </tr> </table> <p align="right"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>      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) <u>Craig L. Ater</u>		(Title) <u>Senior V.P. &amp; CFO</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # ( ) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																															
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																															
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # ( ) _____																																

Facility Name & ID Number Heritage Manor South-Beardstown

# 0042705 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

**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	79	Skilled (SNF)	79	28,835	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	79	TOTALS	79	28,835	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	10,986	7,215	2,824	21,025	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	10,986	7,215	2,824	21,025	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.91%

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 06/30/97

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ 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 2,824

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 South-Beardstown # 0042705 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	122,505	9,642		132,147		132,147	2,039	134,186		1
2	Food Purchase		135,041		135,041		135,041		135,041		2
3	Housekeeping	63,803	11,684		75,487		75,487		75,487		3
4	Laundry	24,514	11,858		36,372		36,372		36,372		4
5	Heat and Other Utilities			130,388	130,388		130,388	904	131,292		5
6	Maintenance	70,018	60,714	37,726	168,458		168,458	9,075	177,533		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>280,840</b>	<b>228,939</b>	<b>168,114</b>	<b>677,893</b>		<b>677,893</b>	<b>12,018</b>	<b>689,911</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director										9
10	Nursing and Medical Records	703,352	51,656	3,514	758,522		758,522		758,522		10
10a	Therapy		155,000	213,684	368,684	(289,761)	78,923	127,371	206,294		10a
11	Activities	42,908	3,267	79	46,254		46,254		46,254		11
12	Social Services	14,492		1,056	15,548		15,548		15,548		12
13	Nurse Aide Training		120		120		120	1,402	1,522		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>760,752</b>	<b>210,043</b>	<b>218,333</b>	<b>1,189,128</b>	<b>(289,761)</b>	<b>899,367</b>	<b>128,773</b>	<b>1,028,140</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	53,300			53,300		53,300	56,236	109,536		17
18	Directors Fees							5,100	5,100		18
19	Professional Services			213,868	213,868		213,868	(205,277)	8,591		19
20	Dues, Fees, Subscriptions & Promotions			90,467	90,467	(70,080)	20,387	(10,963)	9,424		20
21	Clerical & General Office Expenses	60,678	7,703	13,722	82,103		82,103	159,216	241,319		21
22	Employee Benefits & Payroll Taxes			259,585	259,585		259,585	22,834	282,419		22
23	Inservice Training & Education			877	877		877	618	1,495		23
24	Travel and Seminar			7,587	7,587		7,587	(5,588)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			47,271	47,271		47,271	1,574	48,845		26
27	Other (specify):*			6,950	6,950		6,950	(6,950)			27
28	<b>TOTAL General Administration</b>	<b>113,978</b>	<b>7,703</b>	<b>640,327</b>	<b>762,008</b>	<b>(70,080)</b>	<b>691,928</b>	<b>16,800</b>	<b>708,728</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,155,570</b>	<b>446,685</b>	<b>1,026,774</b>	<b>2,629,029</b>	<b>(359,841)</b>	<b>2,269,188</b>	<b>157,591</b>	<b>2,426,779</b>		<b>29</b>

\*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 South-Beardstown

#0042705

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## 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			152,944	152,944		152,944	(11,919)	141,025			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,570	52,570		52,570	5,958	58,528			32
33	Real Estate Taxes			64,022	64,022		64,022		64,022			33
34	Rent-Facility & Grounds							(15,546)	(15,546)			34
35	Rent-Equipment & Vehicles			(546)	(546)		(546)	8,937	8,391			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			268,990	268,990		268,990	(12,570)	256,420			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					289,761	289,761		289,761			39
40	Barber and Beauty Shops	220			220		220		220			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					70,080	70,080		70,080			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	220			220	359,841	360,061		360,061			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,155,790	446,685	1,295,764	2,898,239		2,898,239	145,021	3,043,260			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 South-Beardstown**

# **0042705**

Report Period Beginning: **01/01/2003**

Ending: **12/31/2003**

**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	1,064	35		5
6	Rented Facility Space	(20,789)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,764)	30		9
10	Interest and Other Investment Income	(976)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(795)	20		17
18	Fines and Penalties				18
19	Entertainment	(10,027)	24		19
20	Contributions	(950)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,445)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	27		24
25	Fund Raising, Advertising and Promotional	(12,896)	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				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (82,578)		\$	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)	227,599		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 227,599		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 145,021		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 South-Beardstown

ID# 0042705  
 Report Period Beginning: 01/01/2003  
 Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		1,064	35
6		(20,789)	34
7			7
8			8
9		(19,764)	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(795)	20
18			18
19			24
20		(950)	27
21			21
22		(11,445)	19
23			23
24		(6,000)	27
25		(12,896)	20
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>	(71,575)	49

## STATE OF ILLINOIS

Summary A

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

# 0042705 Report Period Beginning:

01/01/2003 Ending: 12/31/2003

## 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	2,039	0	0	0	0	0	0	0	0	2,039	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	904	0	0	0	0	0	0	0	0	904	5
6	Maintenance	0	0	9,075	0	0	0	0	0	0	0	0	9,075	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	12,018	0	0	0	0	0	0	0	0	12,018	8
	<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	127,371	0	0	0	0	0	0	0	0	0	127,371	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	1,402	0	0	0	0	0	0	0	0	1,402	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>	0	127,371	1,402	0	0	0	0	0	0	0	0	128,773	16
	<b>C. General Administration</b>													
17	Administrative	0	0	56,236	0	0	0	0	0	0	0	0	56,236	17
18	Directors Fees	0	0	5,100	0	0	0	0	0	0	0	0	5,100	18
19	Professional Services	(11,445)	(202,423)	8,591	0	0	0	0	0	0	0	0	(205,277)	19
20	Fees, Subscriptions & Promotions	(13,691)	0	2,728	0	0	0	0	0	0	0	0	(10,963)	20
21	Clerical & General Office Expenses	0	0	159,216	0	0	0	0	0	0	0	0	159,216	21
22	Employee Benefits & Payroll Taxes	0	0	22,834	0	0	0	0	0	0	0	0	22,834	22
23	Inservice Training & Education	0	0	618	0	0	0	0	0	0	0	0	618	23
24	Travel and Seminar	(10,027)	0	4,439	0	0	0	0	0	0	0	0	(5,588)	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	1,574	0	0	0	0	0	0	0	0	1,574	26
27	Other (specify):*	(6,950)	0	0	0	0	0	0	0	0	0	0	(6,950)	27
28	<b>TOTAL General Administration</b>	(42,113)	(202,423)	261,336	0	0	0	0	0	0	0	0	16,800	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(42,113)	(75,052)	274,756	0	0	0	0	0	0	0	0	157,591	29



**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	202,423	Heritage Enterprises, Inc.	100.00%		(202,423)	4
5	V							5
6	V	10a Adjustment for Related Organization	154,362	GreenTree Pharmacy	100.00%	281,733	127,371	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 356,785			\$ 281,733	\$ * (75,052)	14

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

Facility Name & ID Number Heritage Manor South-Beardstown # 0042705 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

**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%	\$ 2,039	\$	2,039	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				904		904	19
20	V	6 Maintenance				9,075		9,075	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				1,402		1,402	26
27	V	14 Program Transportation				0			27
28	V	15 Other				0			28
29	V	17 Administrative				56,236		56,236	29
30	V	18 Directors Fees				5,100		5,100	30
31	V	19 Professional Services				8,591		8,591	31
32	V	20 Fees, Subscription, Promotions				2,728		2,728	32
33	V	21 Clerical & General Office Expenses				159,216		159,216	33
34	V	22 Employee Benefits & Payroll Taxes				22,834		22,834	34
35	V	23 Inservice Training & Education				618		618	35
36	V	24 Travel and Seminar				4,439		4,439	36
37	V	25 Other Admin. Staff Transportation				0			37
38	V	26 Insurance-Prop.Liab.Malpract				1,574		1,574	38
39	Total		\$			\$ 274,756	\$ *	274,756	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				7,845	7,845
17	V	31 Amortization of Pre-Op & Org				0	0
18	V	32 Interest				6,934	6,934
19	V	33 Real Estate Taxes				0	0
20	V	34 Rent-Facility & Grounds				5,243	5,243
21	V	35 Rent-Equipment & Vehicles				7,873	7,873
22	V	36 Other				0	0
23	V	38 Medically Nec Transportation				0	0
24	V	39 Ancillary Service Centers				0	0
25	V	40 Barber and Beauty Shops				0	0
26	V	41 Coffee and Gift Shops				0	0
27	V	42 Other				0	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		\$			\$ 27,895	\$ * 27,895

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

Facility Name & ID Number Heritage Manor South-Beardstown # 0042705 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## 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	Director	Management	26.00	320,135	5	100.00	Director/Salar	\$ 10,524	line 17/18, col 1
2	Tom Jefferson	Secretary	Management	10.00	385,686	5	100.00	Director/Salary	12,680	line 17/18, col 2
3	Craig Hart	Chairman	Management	20.00	372,740	10	100.00	Director/Salary	12,254	line 17/18, col 3
4	Cheryl Lowney	Executive Vice Presi	Management	0.30	222,499	40	100.00	Director/Salary	7,315	line 17/18, col 4
5	Steve Wannemacher	President	Management	0.30	251,231	40	100.00	Director/Salary	8,259	line 17/18, col 5
6	Connie Hoselton	Sr Vice President	Management	0.20	148,865	40	100.00	Salary	4,894	line 17, col 7 6
7	Craig Ater	Sr Vice President	Management	0.20	164,565	40	100.00	Salary	5,410	line 17, col 7 7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 61,336	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 South-Beardstown # 0042705 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

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	2,403	24	\$ 62,023	\$ 79	\$ 2,039	1
2	2	Food Purchase	Beds	2,403	24	0	79	0	2
3	3	Housekeeping	Beds	2,403	24	0	79	0	3
4	4	Laundry	Beds	2,403	24	0	79	0	4
5	5	Heat & Other Utilities	Beds	2,403	24	27,509	79	904	5
6	6	Maintenance	Beds	2,403	24	276,052	79	67,064	6
7	7	Other	Beds	2,403	24	0	79	0	7
8	9	Medical Director	Beds	2,403	24	0	79	0	8
9	10	Nursing & Medical Records	Beds	2,403	24	0	79	0	9
10	11	Activities	Beds	2,403	24	0	79	0	10
11	12	Social Service	Beds	2,403	24	0	79	0	11
12	13	Nurse Aide Training	Beds	2,403	24	42,658	79	42,572	12
13	14	Program Transportation	Beds	2,403	24	0	79	0	13
14	15	Other	Beds	2,403	24	0	79	0	14
15	17	Administrative	Beds	2,403	24	1,710,580	79	0	15
16	18	Directors Fees	Beds	2,403	24	155,144	79	0	16
17	19	Professional Services	Beds	2,403	24	261,316	79	0	17
18	20	Fees, Subscription, Promotions	Beds	2,403	24	82,980	79	0	18
19	21	Clerical & General Office Expense	Beds	2,403	24	4,842,980	79	4,501,882	19
20	22	Employee Benefits & Payroll Tax	Beds	2,403	24	694,554	79	0	20
21	23	Inservice Training & Education	Beds	2,403	24	18,789	79	0	21
22	24	Travel and Seminar	Beds	2,403	24	135,033	79	0	22
23	25	Other Admin. Staff Transportatio	Beds	2,403	24	0	79	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,403	24	47,877	79	0	24
25	TOTALS					\$ 8,357,495	\$ 4,673,541	\$ 274,756	25

Facility Name & ID Number Heritage Manor South-Beardstown # 0042705 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

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	2,403	24	\$	\$	79	\$	1
2	30 Depreciation	Beds	2,403	24	238,628		79	7,845	2
3	31 Amortization of Pre-Op & Org	Beds	2,403	24			79		3
4	32 Interest	Beds	2,403	24	210,931		79	6,934	4
5	33 Real Estate Taxes	Beds	2,403	24			79		5
6	34 Rent-Facility & Grounds	Beds	2,403	24	159,466		79	5,243	6
7	35 Rent-Equipment & Vehicles	Beds	2,403	24	239,478		79	7,873	7
8	36 Other	Beds	2,403	24			79		8
9	38 Medically Nec Transportation	Beds	2,403	24			79		9
10	39 Ancillary Service Centers	Beds	2,403	24			79		10
11	40 Barber and Beauty Shops	Beds	2,403	24			79		11
12	41 Coffee and Gift Shops	Beds	2,403	24			79		12
13	42 Other	Beds	2,403	24			79		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				\$ 848,503	\$		\$ 27,895	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	LSalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	\$ 1,240,000	\$ 964,488	01/15/06	variable	\$ 37,870	1								
2	LSalle National Bank		xx	Mortgage								2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Central Office Allocation		xx	Working Capital							14,700	6								
7	Central Office Allocation		xx	Working Capital							6,934	7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 1,240,000	\$ 964,488			\$ 59,504	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income										(976)	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (976)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 1,240,000	\$ 964,488			\$ 58,528	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 South-Beardstown# 0042705 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## 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 2002 report.	\$	63,432	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.)	\$	62,173	2	
3.	Under or (over) accrual (line 2 minus line 1).	\$	(1,259)	3	
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	65,281	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.	\$	64,022	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1998	8		
		1999	9		
		2000	10		
		2001	11		
		2002	12		
				<b>FOR OHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2002	\$		13	
14	PLUS APPEAL COST FROM LINE 5	\$		14	
15	LESS REFUND FROM LINE 6	\$		15	
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16	

## NOTES:

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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, please call the Office of Health Finance at (217) 782-1630.

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

FACILITY NAME Heritage Manor South-Beardstown COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0042705

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 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>0301101200</u>	<u>Heritage Manor South-Beardstown</u>	\$ <u>58,375.00</u>	\$ <u>58,375.00</u>
2. <u>0301101201</u>	_____	\$ <u>3,798.00</u>	\$ <u>3,798.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>62,173.00</u>	\$ <u>62,173.00</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 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.

Facility Name & ID Number Heritage Manor South-Beardstown# 0042705 Report Period Beginning:01/01/2003 Ending:12/31/2003**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ 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			\$ 25,000	1
2					2
3	TOTALS			\$ 25,000	3

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

# 0042705

Report Period Beginning:

01/01/2003

Ending: 12/31/2003

**XL 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	79			\$ 1,380,638	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Remodel facility--Materials	1997		282,659					
10	Remodel facility--Labor	1997		59,019					
11	Nurse Call System	1997		1,500					
12									
13	Remodel facility--Materials	1998		83,670					
14	Remodel facility--Labor	1998		9,606					
15	Laundry Room Remodel-Materials	1998		17,292					
16	Laundry Room Remodel-Labor	1998		1,367					
17	UST Removal/AST Installation	1998		6,992					
18	A/C Compressor	1998		9,465					
19									
20	Assisted Living Labor	1998		192					
21	Assisted Living Professional Fees	1998		4,128					
22									
23	Assisted Living --Labor	1999		113,254					
24	Assisted Living --Professional Fees	1999		28,883					
25	Assisted Living --Materials	1999		502,491					
26									
27	Door Alarm System	2000		2,727					
28	A/C Compressor	2000		2,984					
29	Compressor -- Walk-in Freezer	2000		2,586					
30	Water Heater	2000		2,804					
31	Assisted Living --Professional Fees	2000		3,356					
32	1st Floor Room Remodel--Labor and Materials	2000		16,618					
33									
34	C/O Allocation						7,845	7,845	
35	Book Depreciation				87,319		71,096	(16,223)	513,496
36									

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

See Page 12A, Line 70 for total

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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor South-Beardstown

# 0042705

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

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	Recirculating Pump	2001	\$ 889	\$		\$	\$		37
38	West entrance Door	2001	1,700						38
39									39
40	Door	2002	2,840						40
41	a/c unit	2002	15,900						41
42	Shower room Wall	2002	1,200						42
43	Cmpressor	2002	13,348						43
44	Alzheimers Unit--Farnworth	2002	2,415						44
45	Sewer Relocation	2002	2,011						45
46									46
47	Sewer Relocation	2003	2,206						47
48	a/c units	2003	10,170						48
49	Computer Board	2003	1,081						49
50	Disposer	2003	1,454						50
51	A/C Unit	2003	5,786						51
52	Rebuild Generator	2003	4,276						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)		\$ 2,597,507	\$ 87,319		\$ 78,941	\$ (8,378)	\$ 513,496	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 South-Beardstown

# 0042705

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

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	\$ 2,597,507	\$ 87,319		\$ 78,941	\$ (8,378)	\$ 513,496		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)	\$ 2,597,507	\$ 87,319		\$ 78,941	\$ (8,378)	\$ 513,496		34

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

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

# 0042705

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## 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	\$ 585,363	\$ 65,625	\$ 62,084	\$ (3,541)		\$ 509,241	71
72	Current Year Purchases	6,516						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 591,879	\$ 65,625	\$ 62,084	\$ (3,541)		\$ 509,241	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)	\$ 3,214,386	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 152,944	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 141,025	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (11,919)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,022,737	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	Assisted Living	\$ 673,734	\$ 19,764	\$ 85,227	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 673,734	\$ 19,764	\$ 85,227	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>/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: \$ 8,391 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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		120		120
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 120	\$	\$ 120
10	SUM OF line 9, col. 1 and 2 (e)	\$	120		

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		hrs	\$		\$ 89,362	\$		\$ 89,362	1
2	Licensed Speech and Language Development Therapist		hrs			15,597			15,597	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			100,875	459		101,334	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				281,911		281,911	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					7,850			7,850	13
14	TOTAL			\$		\$ 213,684	\$ 282,370		\$ 496,054	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.

## STATE OF ILLINOIS

Page 17

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

# 0042705

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(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	\$ 5,534	\$	1
2 Cash-Patient Deposits	8,983		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	315,016		3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	28,446		6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	(1,646,878)		8
9 Other(specify):			9
<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (1,288,899)	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	25,000		13
14 Buildings, at Historical Cost	2,597,505		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	591,879		16
17 Accumulated Depreciation (book methods)	(1,022,737)		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):	8,750		23
<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,200,397	\$	24
<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 911,498	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 99,513	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	8,983		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	158,069		30
31 Accrued Taxes Payable (excluding real estate taxes)	767		31
32 Accrued Real Estate Taxes(Sch.IX-B)	65,281		32
33 Accrued Interest Payable	194		33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 Escrow			36
37			37
<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 332,807	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable	964,488		40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 964,488	\$	45
<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,297,295	\$	46
47 <b>TOTAL EQUITY</b> (page 18, line 24)	\$ (385,797)	\$	47
<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 911,498	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (518,252)	1
2	Restatements (describe):		2
3			3
4	<b>SLF Adjustment</b>	302,007	4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (216,245)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(169,552)	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>	\$ (169,552)	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>	\$ (385,797)	24 *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,650,005	1
2	Discounts and Allowances for all Levels	(680,500)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,969,505	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	515,573	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 515,573	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	(28,360)	11
12	Gift and Coffee Shop	823	12
13	Barber and Beauty Care	1,432	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	20,789	16
17	Sale of Drugs	265,362	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,040	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 261,086	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	976	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 976	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>	\$ 2,747,140	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	677,893	31
32	Health Care	1,189,128	32
33	General Administration	762,008	33
<b>B. Capital Expense</b>			
34	Ownership	268,990	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	220	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37		18,453	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,916,692	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(169,552)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (169,552)	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 South-Beardstown

# 0042705

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

12/31/2003

## 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	1,976	2,080	\$ 42,387	\$ 20.38	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	1,682	1,795	39,552	22.03	3
4	Licensed Practical Nurses	13,919	14,916	218,816	14.67	4
5	Nurse Aides & Orderlies	39,220	42,414	400,461	9.44	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,504	2,720	2,136	0.79	8
9	Activity Director					9
10	Activity Assistants	3,323	3,539	42,908	12.12	10
11	Social Service Workers	1,387	1,593	14,492	9.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,810	16,004	122,505	7.65	15
16	Dishwashers					16
17	Maintenance Workers	5,643	6,217	70,018	11.26	17
18	Housekeepers	9,023	9,435	63,803	6.76	18
19	Laundry	1,751	1,935	24,514	12.67	19
20	Administrator	2,080	2,080	53,300	25.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,840	4,268	60,678	14.22	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)	101,158	108,996	\$ 1,155,570 *	\$ 10.60	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	960	37
38	Nurse Consultant		38
39	Pharmacist Consultant	1,830	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	1,056	45
46	Other(specify)		46
47			47
48			48
49	TOTAL (lines 35 - 48)	\$ 3,846	49

## C. CONTRACT NURSES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference
50	Registered Nurses	\$ 0	50
51	Licensed Practical Nurses	0	51
52	Nurse Aides	0	52
53	TOTAL (lines 50 - 52)	\$	53





Facility Name & ID Number Heritage Manor South-Beardstown# 0042705Report Period Beginning: 01/01/2003Ending: 12/31/2003

## 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. \$ 70,080  
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. \$ 2,144
- (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?  
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: Pellman & Dold The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. Not Complete as of 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.

