

		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>I. IDPH Facility ID Number: <u>0038315</u></p> <p>Facility Name: <u>Heritage Manor-Gibson City</u></p> <p>Address: <u>525 HAZEL DRIVE</u> <u>Gibson City</u> <u>61938</u> Number City Zip Code</p> <p>County: <u>Ford</u></p> <p>Telephone Number: <u>(217) 784-4257</u> Fax # ()</p> <p>IDPA ID Number: <u>370909086002</u></p> <p>Date of Initial License for Current Owners: <u>08/01/80</u></p> <p>Type of Ownership:</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>IRS Exemption Code _____</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>In the event there are further questions about this report, please contact: Name: <u>CRAIG L. ATER</u> Telephone Number: <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	IRS Exemption Code _____	<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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</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 rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Craig L. Ater</u></td> </tr> <tr> <td></td> <td>(Title) <u>Senior V.P. and Chief Financial Officer</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) _____ Fax # () _____</td> </tr> <tr> <td>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Craig L. Ater</u>		(Title) <u>Senior V.P. and Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) _____ Fax # () _____	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																		
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Facility Name & ID Number Heritage Manor-Gibson City

0038315 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	<u>75</u>	Skilled (SNF)	<u>75</u>	<u>27,375</u>	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	<u>75</u>	TOTALS	<u>75</u>	<u>27,375</u>	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	<u>14,808</u>	<u>9,088</u>	<u>824</u>	<u>24,720</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,808</u>	<u>9,088</u>	<u>824</u>	<u>24,720</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.30%

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 08/01/80

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 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

Page 3

Facility Name & ID Number

Heritage Manor-Gibson City

0038315

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
	A. General Services										
1	Dietary	174,748	6,212		180,960		180,960	1,936	182,896		1
2	Food Purchase		86,468		86,468		86,468		86,468		2
3	Housekeeping	64,319	10,583		74,902		74,902		74,902		3
4	Laundry	36,777	9,891		46,668		46,668		46,668		4
5	Heat and Other Utilities			53,010	53,010		53,010	859	53,869		5
6	Maintenance	66,906	20,659	18,633	106,198		106,198	8,616	114,814		6
7	Other (specify):*										7
8	TOTAL General Services	342,750	133,813	71,643	548,206		548,206	11,411	559,617		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	735,220	65,574	224,038	1,024,832		1,024,832		1,024,832		10
10a	Therapy		117,499	53,254	170,753	(242,958)	(72,205)	124,038	51,833		10a
11	Activities	48,088	2,343		50,431		50,431		50,431		11
12	Social Services	25,599	51	2,540	28,190		28,190		28,190		12
13	Nurse Aide Training	4,654	653		5,307		5,307	1,331	6,638		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	813,561	186,120	284,632	1,284,313	(242,958)	1,041,355	125,369	1,166,724		16
	C. General Administration										
17	Administrative	57,000			57,000		57,000	53,389	110,389		17
18	Directors Fees							4,842	4,842		18
19	Professional Services			175,683	175,683		175,683	(167,527)	8,156		19
20	Dues, Fees, Subscriptions & Promotions			54,494	54,494	(41,063)	13,431	479	13,910		20
21	Clerical & General Office Expenses	88,149	7,136	10,393	105,678		105,678	151,154	256,832		21
22	Employee Benefits & Payroll Taxes			312,337	312,337		312,337	21,678	334,015		22
23	Inservice Training & Education			539	539		539	586	1,125		23
24	Travel and Seminar			4,347	4,347		4,347	(2,348)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			33,108	33,108		33,108	1,494	34,602		26
27	Other (specify):*			13,090	13,090		13,090	(13,090)			27
28	TOTAL General Administration	145,149	7,136	603,991	756,276	(41,063)	715,213	50,657	765,870		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,301,460	327,069	960,266	2,588,795	(284,021)	2,304,774	187,437	2,492,211		29

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

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

Facility Name & ID Number

Heritage Manor-Gibson City

#0038315

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	
	D. Ownership											
30	Depreciation			74,698	74,698		74,698	17,463	92,161			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			41,778	41,778		41,778	6,553	48,331			32
33	Real Estate Taxes			40,917	40,917		40,917		40,917			33
34	Rent-Facility & Grounds							4,977	4,977			34
35	Rent-Equipment & Vehicles			4,143	4,143		4,143	6,288	10,431			35
36	Other (specify):*											36
37	TOTAL Ownership			161,536	161,536		161,536	35,281	196,817			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					242,958	242,958		242,958			39
40	Barber and Beauty Shops		310	5,265	5,575		5,575		5,575			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					41,063	41,063		41,063			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		310	5,265	5,575	284,021	289,596		289,596			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,301,460	327,379	1,127,067	2,755,906		2,755,906	222,718	2,978,624			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-Gibson City

0038315

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	(1,186)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,015	30		9
10	Interest and Other Investment Income	(30)	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	(783)	20		17
18	Fines and Penalties				18
19	Entertainment	(6,563)	24		19
20	Contributions	(1,090)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,616)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(1,328)	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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (18,581)		\$	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)	241,299		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 241,299		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 222,718		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	TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Manor-Gibson City

ID# 0038315
 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		(1,186)	35
6		0	34
7			7
8			8
9		10,015	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(783)	20
18			18
19			24
20		(1,090)	27
21			21
22		(5,616)	19
23			23
24		(12,000)	27
25		(1,328)	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	Total	(11,988)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Manor-Gibson City

0038315

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)	
	A. General Services													
1	Dietary	0	0	1,936	0	0	0	0	0	0	0	0	1,936	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	859	0	0	0	0	0	0	0	0	859	5
6	Maintenance	0	0	8,616	0	0	0	0	0	0	0	0	8,616	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	11,411	0	0	0	0	0	0	0	0	11,411	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	124,038	0	0	0	0	0	0	0	0	0	124,038	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	1,331	0	0	0	0	0	0	0	0	1,331	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	124,038	1,331	0	0	0	0	0	0	0	0	125,369	16
	C. General Administration													
17	Administrative	0	0	53,389	0	0	0	0	0	0	0	0	53,389	17
18	Directors Fees	0	0	4,842	0	0	0	0	0	0	0	0	4,842	18
19	Professional Services	(5,616)	(170,067)	8,156	0	0	0	0	0	0	0	0	(167,527)	19
20	Fees, Subscriptions & Promotions	(2,111)	0	2,590	0	0	0	0	0	0	0	0	479	20
21	Clerical & General Office Expenses	0	0	151,154	0	0	0	0	0	0	0	0	151,154	21
22	Employee Benefits & Payroll Taxes	0	0	21,678	0	0	0	0	0	0	0	0	21,678	22
23	Inservice Training & Education	0	0	586	0	0	0	0	0	0	0	0	586	23
24	Travel and Seminar	(6,563)	0	4,215	0	0	0	0	0	0	0	0	(2,348)	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	1,494	0	0	0	0	0	0	0	0	1,494	26
27	Other (specify):*	(13,090)	0	0	0	0	0	0	0	0	0	0	(13,090)	27
28	TOTAL General Administration	(27,380)	(170,067)	248,104	0	0	0	0	0	0	0	0	50,657	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,380)	(46,029)	260,846	0	0	0	0	0	0	0	0	187,437	29

Facility Name & ID Number Heritage Manor-Gibson City

0038315

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

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	170,067	Heritage Enterprises, Inc.	100.00%		(170,067)	4
5	V							5
6	V	10a Adjustment for Related Organization	117,454	GreenTree Pharmacy	100.00%	241,492	124,038	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 287,521			\$ 241,492	\$ * (46,029)	14

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

Facility Name & ID Number Heritage Manor-Gibson City # 0038315 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%	\$ 1,936	\$ 1,936
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				859	859
20	V	6 Maintenance				8,616	8,616
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				1,331	1,331
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				53,389	53,389
30	V	18 Directors Fees				4,842	4,842
31	V	19 Professional Services				8,156	8,156
32	V	20 Fees, Subscription, Promotions				2,590	2,590
33	V	21 Clerical & General Office Expenses				151,154	151,154
34	V	22 Employee Benefits & Payroll Taxes				21,678	21,678
35	V	23 Inservice Training & Education				586	586
36	V	24 Travel and Seminar				4,215	4,215
37	V	25 Other Admin. Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				1,494	1,494
39	Total		\$			\$ 260,846	\$ * 260,846

* 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				7,448	7,448
17	V	31 Amortization of Pre-Op & Org				0	
18	V	32 Interest				6,583	6,583
19	V	33 Real Estate Taxes				0	
20	V	34 Rent-Facility & Grounds				4,977	4,977
21	V	35 Rent-Equipment & Vehicles				7,474	7,474
22	V	36 Other				0	
23	V	38 Medically Nec Transportation				0	
24	V	39 Ancillary Service Centers				0	
25	V	40 Barber and Beauty Shops				0	
26	V	41 Coffee and Gift Shops				0	
27	V	42 Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 26,482	\$ * 26,482

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

Facility Name & ID Number Heritage Manor-Gibson City # 0038315 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	\$ 9,992	line 17/18, col 1
2	Tom Jefferson	Secretary	Management	10.00	385,686	5	100.00	Director/Salary	12,038	line 17/18, col 2
3	Craig Hart	Chairman	Management	20.00	372,740	10	100.00	Director/Salary	11,634	line 17/18, col 3
4	Cheryl Lowney	Executive Vice Presi	Management	0.30	222,499	40	100.00	Director/Salary	6,944	line 17/18, col 4
5	Steve Wannemacher	President	Management	0.30	251,231	40	100.00	Director/Salary	7,841	line 17/18, col 5
6	Connie Hoselton	Sr Vice President	Management	0.20	148,865	40	100.00	Salary	4,646	line 17, col 7 6
7	Craig Ater	Sr Vice President	Management	0.20	164,565	40	100.00	Salary	5,136	line 17, col 7 7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 58,231	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-Gibson City # 0038315 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	\$ 62,023	75	\$ 1,936	1
2	2 Food Purchase	Beds	2,403	24	0	0	75	0	2
3	3 Housekeeping	Beds	2,403	24	0	0	75	0	3
4	4 Laundry	Beds	2,403	24	0	0	75	0	4
5	5 Heat & Other Utilities	Beds	2,403	24	27,509	0	75	859	5
6	6 Maintenance	Beds	2,403	24	276,052	67,064	75	8,616	6
7	7 Other	Beds	2,403	24	0	0	75	0	7
8	9 Medical Director	Beds	2,403	24	0	0	75	0	8
9	10 Nursing & Medical Records	Beds	2,403	24	0	0	75	0	9
10	11 Activities	Beds	2,403	24	0	0	75	0	10
11	12 Social Service	Beds	2,403	24	0	0	75	0	11
12	13 Nurse Aide Training	Beds	2,403	24	42,658	42,572	75	1,331	12
13	14 Program Transportation	Beds	2,403	24	0	0	75	0	13
14	15 Other	Beds	2,403	24	0	0	75	0	14
15	17 Administrative	Beds	2,403	24	1,710,580	0	75	53,389	15
16	18 Directors Fees	Beds	2,403	24	155,144	0	75	4,842	16
17	19 Professional Services	Beds	2,403	24	261,316	0	75	8,156	17
18	20 Fees, Subscription, Promotions	Beds	2,403	24	82,980	0	75	2,590	18
19	21 Clerical & General Office Expense	Beds	2,403	24	4,842,980	4,501,882	75	151,154	19
20	22 Employee Benefits & Payroll Tax	Beds	2,403	24	694,554	0	75	21,678	20
21	23 Inservice Training & Education	Beds	2,403	24	18,789	0	75	586	21
22	24 Travel and Seminar	Beds	2,403	24	135,033	0	75	4,215	22
23	25 Other Admin. Staff Transportatio	Beds	2,403	24	0	0	75	0	23
24	26 Insurance-Prop.Liab.Malpract	Beds	2,403	24	47,877	0	75	1,494	24
25	TOTALS				\$ 8,357,495	\$ 4,673,541		\$ 260,846	25

Facility Name & ID Number Heritage Manor-Gibson City # 0038315 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	\$	\$	75	\$	1
2	30 Depreciation	Beds	2,403	24	238,628		75	7,448	2
3	31 Amortization of Pre-Op & Org	Beds	2,403	24			75		3
4	32 Interest	Beds	2,403	24	210,931		75	6,583	4
5	33 Real Estate Taxes	Beds	2,403	24			75		5
6	34 Rent-Facility & Grounds	Beds	2,403	24	159,466		75	4,977	6
7	35 Rent-Equipment & Vehicles	Beds	2,403	24	239,478		75	7,474	7
8	36 Other	Beds	2,403	24			75		8
9	38 Medically Nec Transportation	Beds	2,403	24			75		9
10	39 Ancillary Service Centers	Beds	2,403	24			75		10
11	40 Barber and Beauty Shops	Beds	2,403	24			75		11
12	41 Coffee and Gift Shops	Beds	2,403	24			75		12
13	42 Other	Beds	2,403	24			75		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	\$		\$ 26,482	25

Facility Name & ID Number Heritage Manor-Gibson City # 0038315 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1	1	xx	Mortgage	4640 plus Int	01/15/99	\$ 2,433,749	\$ 771,263	01/15/06	variable	\$ 26,944	1									
2	2	xx	Mortgage							4,350	2									
3	3										3									
4	4										4									
5	5										5									
	Working Capital																			
6	6	xx	Working Capital							10,484	6									
7	7	xx	Working Capital							6,583	7									
8	8										8									
9	9					\$ 2,433,749	\$ 771,263			\$ 48,361	9									
	B. Non-Facility Related*																			
10	10									(30)	10									
11	11										11									
12	12										12									
13	13										13									
14	14					\$	\$			(30)	14									
15	15					\$ 2,433,749	\$ 771,263			\$ 48,331	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-Gibson City# 0038315 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

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

B. Real Estate Taxes

		Important , 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.	\$	40,455	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.)	\$	39,694	2															
3.	Under or (over) accrual (line 2 minus line 1).	\$	(761)	3															
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	41,678	4															
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5															
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6															
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	40,917	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:		1998	8	<table border="1"> <tr> <td colspan="2">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY		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
FOR OHF USE ONLY																			
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																	
	1999	9																	
	2000	10																	
	2001	11																	
	2002	12																	

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 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-Gibson City COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0038315

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>091111479017</u>	<u>Heritage Manor-Gibson City</u>	\$ <u>143.00</u>	\$ <u>143.00</u>
2. <u>091111482001</u>	<u>Heritage Manor-Gibson City</u>	\$ <u>39,550.00</u>	\$ <u>39,550.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>39,693.00</u>	\$ <u>39,693.00</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-Gibson City

0038315 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).

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			\$ 20,000	1
2					2
3	TOTALS			\$ 20,000	3

Facility Name & ID Number Heritage Manor-Gibson City# 0038315

Report Period Beginning:

01/01/2003Ending: 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	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	75	1963		\$ 815,350	\$		\$	\$	\$
5		1966		912,769					
6		1999							
7									
8									
Improvement Type**									
9	1981 Improvements	1981		41,753					
10	1982 Improvements	1982		6,437					
11	1983 Improvements	1983		240					
12	1984 Improvements	1984		873					
13	1985 Improvements	1985		7,530					
14	1986 Improvements	1986		20,979					
15	1987 Improvements	1987		2,222					
16	1988 Improvements	1988		2,452					
17	1989 Improvements	1989		28,639					
18	1990 Improvements	1990		99,326					
19	1991 Improvements	1991		36,637					
20	1993 Improvements	1993		40,838					
21	1994 Improvements	1994		66,399					
22	1995 Improvements	1995		1,060					
23	WINDOW REPLACEMENTS	1996		25,247					
24	WATER HEATER	1996		1,639					
25	RESIDENT ROOM REMODEL/PAINTING	1996		7,584					
26	Parking Lot	1998		12,299					
27									
28	Smoke Dampers	1999		5,256					
29	Water Heater	1999		1,971					
30	Garbage Disposal	1999		1,693					
31	Heat/Cool compressor	1999		3,277					
32	Smoke Dampers	2000		1,295					
33									
34	C/O Allocation						7,448	7,448	
35	Book Depreciation				58,509		68,963	10,454	1,271,697
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-Gibson City

0038315

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	Temperature Control Unit	2001	\$ 1,700	\$		\$	\$	\$	37
38	AC Replacement	2001	4,400						38
39	Smoke Detection System								39
40									40
41	Smoke Detection System	2002	1,775						41
42	Landscaping	2002	1,425						42
43	Fire Supression	2002	4,458						43
44	Water Heater	2002	2,396						44
45	Keypad Perimeter	2002	941						45
46	Sealcoat Parking Lot	2002	1,371						46
47	Garbage Disposal	2002	1,520						47
48	Hot Water Tank	2002	3,168						48
49	Rehab Hallway--Wallpaper/Paint	2002	14,442						49
50									50
51	Exterior Doors	2003	2,195						51
52	Roof Replacement	2003	28,555						52
53	Security Door	2003	1,116						53
54	Water Heater	2003	1,999						54
55	Water Tank	2003	1,836						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)		\$ 2,217,062	\$ 58,509		\$ 76,411	\$ 17,902	\$ 1,271,697	70

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

Facility Name & ID Number Heritage Manor-Gibson City

0038315

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		\$ 2,217,062	\$ 58,509		\$ 76,411	\$ 17,902	\$ 1,271,697	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)		\$ 2,217,062	\$ 58,509		\$ 76,411	\$ 17,902	\$ 1,271,697	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 296,900	\$ 16,188	\$ 15,750	\$ (438)		\$ 250,562	71
72	Current Year Purchases	5,828						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 302,728	\$ 16,188	\$ 15,750	\$ (438)		\$ 250,562	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,539,790	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 74,697	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 92,161	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,464	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,522,259	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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: \$ 10,431 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	TOTAL		\$	\$	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		653		653
3	Classroom Wages (a)		4,654		4,654
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 5,307	\$	\$ 5,307
10	SUM OF line 9, col. 1 and 2 (e)	\$	5,307		

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	\$		\$ 24,434	\$		\$ 24,434	1
2	Licensed Speech and Language Development Therapist		hrs			2,784			2,784	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			24,569	45		24,614	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				241,491		241,491	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					1,467			1,467	13
14	TOTAL			\$		\$ 53,254	\$ 241,536		\$ 294,790	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

Facility Name & ID Number Heritage Manor-Gibson City

0038315

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*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,276	1
2	Cash-Patient Deposits	3,315	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	225,724	3
4	Supply Inventory (priced at)		4
5	Short-Term Investments		5
6	Prepaid Insurance	12,754	6
7	Other Prepaid Expenses		7
8	Accounts Receivable (owners or related parties)	2,077,468	8
9	Other(specify):		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,334,537	10
B. Long-Term Assets			
11	Long-Term Notes Receivable		11
12	Long-Term Investments		12
13	Land	20,000	13
14	Buildings, at Historical Cost	2,040,644	14
15	Leasehold Improvements, at Historical Cost		15
16	Equipment, at Historical Cost	352,506	16
17	Accumulated Depreciation (book methods)	(995,487)	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):	9,063	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,426,726	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,761,263	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 39,748	26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	3,315	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	119,782	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,319	31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,678	32
33	Accrued Interest Payable	2,170	33
34	Deferred Compensation		34
35	Federal and State Income Taxes		35
Other Current Liabilities(specify):			
36	Escrow		36
37			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 208,012	38
D. Long-Term Liabilities			
39	Long-Term Notes Payable		39
40	Mortgage Payable	771,263	40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 771,263	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 979,275	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,781,988	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,761,263	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,814,732	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,814,732	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(32,744)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (32,744)	17
	B. Transfers (Itemize):		
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)	\$ 2,781,988	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Manor-Gibson City

0038315

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,742,995	1
2	Discounts and Allowances for all Levels	(380,179)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,362,816	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	149,701	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 149,701	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	3,655	11
12	Gift and Coffee Shop	1,667	12
13	Barber and Beauty Care	6,899	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	198,314	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	80	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 210,615	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	30	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,723,162	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	548,206	31
32	Health Care	1,284,313	32
33	General Administration	756,276	33
B. Capital Expense			
34	Ownership	161,536	34
C. Ancillary Expense			
35	Special Cost Centers	5,575	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,755,906	40
41	Income before Income Taxes (line 30 minus line 40)**	(32,744)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (32,744)	43

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

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

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

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

Facility Name & ID Number Heritage Manor-Gibson City

0038315

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	1,992	2,080	\$ 40,679	\$ 19.56	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	6,325	6,585	134,614	20.44	3
4	Licensed Practical Nurses	4,290	4,597	80,504	17.51	4
5	Nurse Aides & Orderlies	42,978	46,132	452,519	9.81	5
6	Nurse Aide Trainees	746	746	4,654	6.24	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,810	1,999	26,904	13.46	8
9	Activity Director					9
10	Activity Assistants	4,838	5,314	48,088	9.05	10
11	Social Service Workers	1,774	2,113	25,599	12.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,749	18,128	174,748	9.64	15
16	Dishwashers					16
17	Maintenance Workers	5,582	6,101	66,906	10.97	17
18	Housekeepers	7,333	7,808	64,319	8.24	18
19	Laundry	3,574	4,005	36,777	9.18	19
20	Administrator	2,080	2,080	57,000	27.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,173	6,795	88,149	12.97	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)	106,244	114,483	\$ 1,301,460 *	\$ 11.37	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	4,800	36
37	Medical Records Consultant	1,800	37
38	Nurse Consultant		38
39	Pharmacist Consultant	2,118	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	2,540	45
46	Other(specify)		46
47			47
48			48
49	TOTAL (lines 35 - 48)	\$ 11,258	49

C. CONTRACT NURSES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference
50	Registered Nurses	\$ 63,816	50
51	Licensed Practical Nurses	87,329	51
52	Nurse Aides	68,330	52
53	TOTAL (lines 50 - 52)	\$ 219,475	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Paula Johnson	Admin	0	\$ 57,000	Workers' Compensation Insurance	\$ 23,437	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	9,211	Advertising: Employee Recruitment	4,938	
				FICA Taxes	99,562	Health Care Worker Background Check (Indicate # of checks performed _____)	322	
				Employee Health Insurance	152,010	Central Office Allocation	2,590	
				Employee Meals		Promotional Advertising	858	
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations	470	
				Employee Hepatitis Vaccine	647	Dues and Subscriptions	5,530	
				Employee Benefits -	27,470	License and Fees	1,313	
				Employee Benefits - central office	21,678			
						Less: Public Relations Expense	(470)	
						Non-allowable advertising	(783)	
						Yellow page advertising	(858)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 57,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 334,015	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,910	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								1,429
								27
							Seminar Expense	2,891
							Non Allowable	(6,563)
							Central Office Allocation	4,215
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL	\$ 1,999
C. Professional Services								
Vendor/Payee	Type		Amount					
Heritage Enterprises	Management Fees		\$ 170,067					
			0					
			0					
			0					
Legal Fees (Adjusted to zero)			5,616					
			0					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 175,683					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor-Gibson City# 0038315Report 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. \$ 41,063
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. \$ 3,880
- (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.

