

		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>0038273</u></p> <p><b>Facility Name:</b> <u>Heritage Manor-Mount Sterling</u></p> <p><b>Address:</b> <u>CAMDEN ROAD</u> <u>Mt. Sterling</u> <u>61938</u>  Number City Zip Code</p> <p><b>County:</b> <u>Brown</u></p> <p><b>Telephone Number:</b> <u>(217) 773-3377</u> Fax # ( )</p> <p><b>IDPA ID Number:</b> <u>370909086009</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>07/01/85</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>  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	<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 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>Craig L. Ater</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 1039">(Title) <u>Senior V.P. &amp; CFO</u> (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>	Paid Preparer	(Title) <u>Senior V.P. &amp; CFO</u> (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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Facility Name & ID Number Heritage Manor-Mount Sterling

# 0038273 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>87</u>	Skilled (SNF)	<u>87</u>	<u>31,755</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>87</u>	TOTALS	<u>87</u>	<u>31,755</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	4 Other		
8	SNF	<u>11,867</u>	<u>6,200</u>	<u>2,045</u>	<u>20,112</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>11,867</u>	<u>6,200</u>	<u>2,045</u>	<u>20,112</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.33%

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 07/01/85

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 2,045

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-Mount Sterling # 0038273 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	116,610	9,060		125,670		125,670	2,246	127,916		1
2	Food Purchase		80,186		80,186		80,186		80,186		2
3	Housekeeping	69,307	12,703		82,010		82,010		82,010		3
4	Laundry	22,285	9,198		31,483		31,483		31,483		4
5	Heat and Other Utilities			74,168	74,168		74,168	996	75,164		5
6	Maintenance	21,634	30,332	23,228	75,194		75,194	9,994	85,188		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	229,836	141,479	97,396	468,711		468,711	13,236	481,947		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			2,400	2,400		2,400		2,400		9
10	Nursing and Medical Records	707,482	27,937	3,206	738,625		738,625		738,625		10
10a	Therapy		156,991	121,227	278,218	(279,327)	(1,109)	105,461	104,352		10a
11	Activities	17,464	3,566		21,030		21,030		21,030		11
12	Social Services	20,142		1,498	21,640		21,640		21,640		12
13	Nurse Aide Training	2,642	1,682		4,324		4,324	1,544	5,868		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	747,730	190,176	128,331	1,066,237	(279,327)	786,910	107,005	893,915		16
	<b>C. General Administration</b>										
17	Administrative	48,000			48,000		48,000	61,931	109,931		17
18	Directors Fees							5,617	5,617		18
19	Professional Services			144,064	144,064		144,064	(134,603)	9,461		19
20	Dues, Fees, Subscriptions & Promotions			66,556	66,556	(47,633)	18,923	(8,528)	10,395		20
21	Clerical & General Office Expenses	58,899	6,227	12,124	77,250		77,250	175,339	252,589		21
22	Employee Benefits & Payroll Taxes			218,272	218,272		218,272	25,146	243,418		22
23	Inservice Training & Education			762	762		762	680	1,442		23
24	Travel and Seminar			8,077	8,077		8,077	(6,078)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			42,027	42,027		42,027	1,733	43,760		26
27	Other (specify):*			13,101	13,101		13,101	(13,082)	19		27
28	<b>TOTAL General Administration</b>	106,899	6,227	504,983	618,109	(47,633)	570,476	108,155	678,631		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,084,465	337,882	730,710	2,153,057	(326,960)	1,826,097	228,396	2,054,493		29

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

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

Facility Name &amp; ID Number

Heritage Manor-Mount Sterling

#0038273

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			97,983	97,983		97,983	3,200	101,183			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,905	49,905		49,905	7,547	57,452			32
33	Real Estate Taxes			37,476	37,476		37,476		37,476			33
34	Rent-Facility & Grounds							5,773	5,773			34
35	Rent-Equipment & Vehicles			1,512	1,512		1,512	8,214	9,726			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			186,876	186,876		186,876	24,734	211,610			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					279,327	279,327		279,327			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					47,633	47,633		47,633			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>					326,960	326,960		326,960			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,084,465	337,882	917,586	2,339,933		2,339,933	253,130	2,593,063			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-Mount Sterling

# 0038273

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	(456)	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	(5,439)	30		9
10	Interest and Other Investment Income	(90)	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	(418)	20		17
18	Fines and Penalties				18
19	Entertainment	(10,967)	24		19
20	Contributions	(1,082)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(45)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(11,114)	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>	\$ (41,611)		\$	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)	294,741		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 294,741		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 253,130		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-Mount Sterling

ID# 0038273

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		(456)	35
6		0	34
7			7
8			8
9		(5,439)	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(418)	20
18			18
19			24
20		(1,082)	27
21			21
22		(45)	19
23			23
24		(12,000)	27
25		(11,114)	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>	(30,554)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Mount Sterling

# 0038273

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	2,246	0	0	0	0	0	0	0	0	2,246	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	996	0	0	0	0	0	0	0	0	996	5
6	Maintenance	0	0	9,994	0	0	0	0	0	0	0	0	9,994	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	13,236	0	0	0	0	0	0	0	0	13,236	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	105,461	0	0	0	0	0	0	0	0	0	105,461	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	1,544	0	0	0	0	0	0	0	0	1,544	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	105,461	1,544	0	0	0	0	0	0	0	0	107,005	16
	<b>C. General Administration</b>													
17	Administrative	0	0	61,931	0	0	0	0	0	0	0	0	61,931	17
18	Directors Fees	0	0	5,617	0	0	0	0	0	0	0	0	5,617	18
19	Professional Services	(45)	(144,019)	9,461	0	0	0	0	0	0	0	0	(134,603)	19
20	Fees, Subscriptions & Promotions	(11,532)	0	3,004	0	0	0	0	0	0	0	0	(8,528)	20
21	Clerical & General Office Expenses	0	0	175,339	0	0	0	0	0	0	0	0	175,339	21
22	Employee Benefits & Payroll Taxes	0	0	25,146	0	0	0	0	0	0	0	0	25,146	22
23	Inservice Training & Education	0	0	680	0	0	0	0	0	0	0	0	680	23
24	Travel and Seminar	(10,967)	0	4,889	0	0	0	0	0	0	0	0	(6,078)	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	1,733	0	0	0	0	0	0	0	0	1,733	26
27	Other (specify):*	(13,082)	0	0	0	0	0	0	0	0	0	0	(13,082)	27
28	<b>TOTAL General Administration</b>	(35,626)	(144,019)	287,800	0	0	0	0	0	0	0	0	108,155	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(35,626)	(38,558)	302,580	0	0	0	0	0	0	0	0	228,396	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	144,019	Heritage Enterprises, Inc.	100.00%		(144,019)	4
5	V							5
6	V	10a Adjustment for Related Organization	156,918	GreenTree Pharmacy	100.00%	262,379	105,461	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 300,937			\$ 262,379	\$ * (38,558)	14

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

Facility Name & ID Number Heritage Manor-Mount Sterling # 0038273 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%	\$ 2,246	\$	2,246	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				996		996	19
20	V	6 Maintenance				9,994		9,994	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				1,544		1,544	26
27	V	14 Program Transportation				0			27
28	V	15 Other				0			28
29	V	17 Administrative				61,931		61,931	29
30	V	18 Directors Fees				5,617		5,617	30
31	V	19 Professional Services				9,461		9,461	31
32	V	20 Fees, Subscription, Promotions				3,004		3,004	32
33	V	21 Clerical & General Office Expenses				175,339		175,339	33
34	V	22 Employee Benefits & Payroll Taxes				25,146		25,146	34
35	V	23 Inservice Training & Education				680		680	35
36	V	24 Travel and Seminar				4,889		4,889	36
37	V	25 Other Admin. Staff Transportation				0			37
38	V	26 Insurance-Prop.Liab.Malpract				1,733		1,733	38
39	Total		\$			\$ 302,580	\$ *	302,580	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				8,639	8,639
17	V	31 Amortization of Pre-Op & Org				0	
18	V	32 Interest				7,637	7,637
19	V	33 Real Estate Taxes				0	
20	V	34 Rent-Facility & Grounds				5,773	5,773
21	V	35 Rent-Equipment & Vehicles				8,670	8,670
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		\$			\$ 30,719	\$ * 30,719

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

Facility Name & ID Number Heritage Manor-Mount Sterling # 0038273 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	\$ 11,589	line 17/18, col 1
2	Tom Jefferson	Secretary	Management	10.00	385,686	5	100.00	Director/Salary	13,964	line 17/18, col 2
3	Craig Hart	Chairman	Management	20.00	372,740	10	100.00	Director/Salary	13,495	line 17/18, col 3
4	Cheryl Lowney	Executive Vice Presi	Management	0.30	222,499	40	100.00	Director/Salary	8,056	line 17/18, col 4
5	Steve Wannemacher	President	Management	0.30	251,231	40	100.00	Director/Salary	9,096	line 17/18, col 5
6	Connie Hoselton	Sr Vice President	Management	0.20	148,865	40	100.00	Salary	5,390	line 17, col 7 6
7	Craig Ater	Sr Vice President	Management	0.20	164,565	40	100.00	Salary	5,958	line 17, col 7 7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 67,548	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-Mount Sterling # 0038273 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	87	\$ 2,246	1
2	2 Food Purchase	Beds	2,403	24	0	0	87	0	2
3	3 Housekeeping	Beds	2,403	24	0	0	87	0	3
4	4 Laundry	Beds	2,403	24	0	0	87	0	4
5	5 Heat & Other Utilities	Beds	2,403	24	27,509	0	87	996	5
6	6 Maintenance	Beds	2,403	24	276,052	67,064	87	9,994	6
7	7 Other	Beds	2,403	24	0	0	87	0	7
8	9 Medical Director	Beds	2,403	24	0	0	87	0	8
9	10 Nursing & Medical Records	Beds	2,403	24	0	0	87	0	9
10	11 Activities	Beds	2,403	24	0	0	87	0	10
11	12 Social Service	Beds	2,403	24	0	0	87	0	11
12	13 Nurse Aide Training	Beds	2,403	24	42,658	42,572	87	1,544	12
13	14 Program Transportation	Beds	2,403	24	0	0	87	0	13
14	15 Other	Beds	2,403	24	0	0	87	0	14
15	17 Administrative	Beds	2,403	24	1,710,580	0	87	61,931	15
16	18 Directors Fees	Beds	2,403	24	155,144	0	87	5,617	16
17	19 Professional Services	Beds	2,403	24	261,316	0	87	9,461	17
18	20 Fees, Subscription, Promotions	Beds	2,403	24	82,980	0	87	3,004	18
19	21 Clerical & General Office Expense	Beds	2,403	24	4,842,980	4,501,882	87	175,339	19
20	22 Employee Benefits & Payroll Tax	Beds	2,403	24	694,554	0	87	25,146	20
21	23 Inservice Training & Education	Beds	2,403	24	18,789	0	87	680	21
22	24 Travel and Seminar	Beds	2,403	24	135,033	0	87	4,889	22
23	25 Other Admin. Staff Transportatio	Beds	2,403	24	0	0	87	0	23
24	26 Insurance-Prop.Liab.Malpract	Beds	2,403	24	47,877	0	87	1,733	24
25	TOTALS				\$ 8,357,495	\$ 4,673,541		\$ 302,580	25

Facility Name & ID Number Heritage Manor-Mount Sterling # 0038273 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	\$	\$	87	\$	1
2	30 Depreciation	Beds	2,403	24	238,628		87	8,639	2
3	31 Amortization of Pre-Op & Org	Beds	2,403	24			87		3
4	32 Interest	Beds	2,403	24	210,931		87	7,637	4
5	33 Real Estate Taxes	Beds	2,403	24			87		5
6	34 Rent-Facility & Grounds	Beds	2,403	24	159,466		87	5,773	6
7	35 Rent-Equipment & Vehicles	Beds	2,403	24	239,478		87	8,670	7
8	36 Other	Beds	2,403	24			87		8
9	38 Medically Nec Transportation	Beds	2,403	24			87		9
10	39 Ancillary Service Centers	Beds	2,403	24			87		10
11	40 Barber and Beauty Shops	Beds	2,403	24			87		11
12	41 Coffee and Gift Shops	Beds	2,403	24			87		12
13	42 Other	Beds	2,403	24			87		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	\$		\$ 30,719	25

Facility Name & ID Number Heritage Manor-Mount Sterling # 0038273 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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	1	xx	Mortgage	4640 plus Int	01/15/99	\$ 1,073,651	\$ 948,392	01/15/06	variable	\$ 33,132	1									
2	2	xx	Mortgage							4,591	2									
3	3										3									
4	4										4									
5	5										5									
	<b>Working Capital</b>																			
6	6	xx	Working Capital							12,182	6									
7	7	xx	Working Capital							7,637	7									
8	8										8									
9	9					\$ 1,073,651	\$ 948,392			\$ 57,542	9									
	<b>B. Non-Facility Related*</b>																			
10	10									(90)	10									
11	11										11									
12	12										12									
13	13										13									
14	14					\$	\$			(90)	14									
15	15					\$ 1,073,651	\$ 948,392			\$ 57,452	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-Mount Sterling# 0038273 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.	\$	37,054	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.)	\$	36,356	2	
3.	Under or (over) accrual (line 2 minus line 1).	\$	(698)	3	
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	38,174	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.	\$	37,476	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-Mount Sterling COUNTY Brown

FACILITY IDPH LICENSE NUMBER 0038273

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>0519400100</u>	<u>Heritage Manor-Mount Sterling</u>	\$ <u>36,356.00</u>	\$ <u>36,356.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u>36,356.00</u>	\$ <u>36,356.00</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 &amp; ID Number Heritage Manor-Mount Sterling

# 0038273 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			\$ 8,000	1
2					2
3	TOTALS			\$ 8,000	3

**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	87			\$ 914,680	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	1987 Improvements	1987		17,047					
10	1987 Improvements	1987		73,700					
11	1988 Improvements	1988		25,324					
12	1989 Improvements	1989		64,856					
13	1990 Improvements	1990		14,699					
14	1991 Improvements	1991		18,519					
15	1992 Improvements	1992		18,102					
16	1993 Improvements	1993		54,992					
17	1994 Improvements	1994		114,380					
18	1995 Improvements	1995		22,646					
19	Fire Alarm System	1996		27,410					
20	Electrical Wire--Resident Rooms	1996		2,675					
21	Drainage System	1996		5,100					
22	Code Alert	1996		6,916					
23	Resident Room Remodel	1996		26,925					
24	Physical Therapy Room Remodel	1996		6,725					
25									
26									
27									
28									
29									
30									
31									
32									
33									
34	C/O Allocation						8,639	8,639	
35	Book Depreciation				64,571		59,132	(5,439)	710,205
36									

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

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

See Page 12A, Line 70 for total

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	Shower/Remodel	1997	\$ 6,033	\$		\$	\$	\$	37
38	Air Conditioner	1997	1,365						38
39	Resident Room Remodel	1997	199,404						39
40									40
41	Garbage Disposal	1998	797						41
42									42
43	Gerator Repair	1999	5,712						43
44	Kitchen Air Conditioner	1999	1,450						44
45									45
46	Door Monitor System	2000	5,196						46
47	Water Heater	2000	3,995						47
48	Sink Installation & Faucet	2000	1,736						48
49									49
50	Water Main Repair	2001	2,308						50
51	Water Heater	2001	3,016						51
52									52
53	A/C Unit	2002	2,634						53
54									54
55	A/C Unit	2003	3,024						55
56	Seal Asphalt	2003	3,538						56
57	Roof	2003	9,616						57
58	Sewer Repair	2003	2,275						58
59	A/C Unit	2003	1,377						59
60	Door	2003	2,283						60
61	Water Softener	2003	1,375						61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,671,830	\$ 64,571		\$ 67,771	\$ 3,200	\$ 710,205	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-Mount Sterling

# 0038273

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		\$ 1,671,830	\$ 64,571		\$ 67,771	\$ 3,200	\$ 710,205	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)		\$ 1,671,830	\$ 64,571		\$ 67,771	\$ 3,200	\$ 710,205	34

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

Facility Name &amp; ID Number Heritage Manor-Mount Sterling

# 0038273

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	\$ 503,764	\$ 33,412	\$ 33,412	\$		\$ 469,405	71
72	Current Year Purchases	2,111						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 505,875	\$ 33,412	\$ 33,412	\$		\$ 469,405	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)	\$ 2,185,705	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 97,983	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,183	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,200	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,179,610	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	Consulting Fees	\$ 20,283	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 20,283	\$	\$	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: \$ 9,726 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		1,682		1,682
3	Classroom Wages (a)		2,642		2,642
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 4,324	\$	\$ 4,324
10	SUM OF line 9, col. 1 and 2 (e)	\$	4,324		

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	\$		\$ 46,038	\$	\$ 46,038	1	
2	Licensed Speech and Language Development Therapist		hrs			5,648		5,648	2	
3	Licensed Recreational Therapist		hrs						3	
4	Licensed Physical Therapist		hrs			52,665	0	52,665	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				262,451	262,451	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs						10	
11	Academic Education		hrs						11	
12	Exceptional Care Program								12	
13	Other (specify):					16,876		16,876	13	
14	TOTAL			\$		\$ 121,227	\$ 262,451	\$ 383,678	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number Heritage Manor-Mount Sterling

# 0038273

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	\$ 11,195	\$	1
2 Cash-Patient Deposits	5,978		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	274,920		3
4 Supply Inventory (priced at )			4
5 Short-Term Investments			5
6 Prepaid Insurance	16,951		6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	16,014		8
9 Other(specify):			9
<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 325,058	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	125,400		13
14 Buildings, at Historical Cost	1,785,750		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	439,299		16
17 Accumulated Depreciation (book methods)	(1,188,307)		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):	9,565		23
<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,171,707	\$	24
<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,496,765	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 42,989	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	5,978		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	123,484		30
31 Accrued Taxes Payable (excluding real estate taxes)	842		31
32 Accrued Real Estate Taxes(Sch.IX-B)	38,174		32
33 Accrued Interest Payable	2,669		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>	\$ 214,136	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable	948,392		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>	\$ 948,392	\$	45
<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,162,528	\$	46
47 <b>TOTAL EQUITY</b> (page 18, line 24)	\$ 334,237	\$	47
<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,496,765	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>380,613</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>380,613</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(46,376)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(46,376)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>334,237</b>	<b>24</b> *

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

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,220,604	1
2	Discounts and Allowances for all Levels	(487,078)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,733,526	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	279,940	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 279,940	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,334	11
12	Gift and Coffee Shop	2,075	12
13	Barber and Beauty Care	382	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	276,208	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 280,001	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	90	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 90	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>	\$ 2,293,557	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	468,711	31
32	Health Care	1,066,237	32
33	General Administration	618,109	33
<b>B. Capital Expense</b>			
34	Ownership	186,876	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,339,933	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(46,376)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (46,376)	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-Mount Sterling

# 0038273

Report Period Beginning: 01/01/2003

Ending:

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	2,032	\$ 2,096	\$ 43,288	\$ 20.65	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	3,344	3,740	72,208	19.31	3
4	Licensed Practical Nurses	11,560	12,740	184,145	14.45	4
5	Nurse Aides & Orderlies	35,991	39,064	391,117	10.01	5
6	Nurse Aide Trainees	388	388	2,642	6.81	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,500	1,620	16,724	10.32	8
9	Activity Director					9
10	Activity Assistants	1,873	2,081	17,464	8.39	10
11	Social Service Workers	1,923	2,101	20,142	9.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,667	14,858	116,610	7.85	15
16	Dishwashers					16
17	Maintenance Workers	2,118	2,302	21,634	9.40	17
18	Housekeepers	8,694	9,412	69,307	7.36	18
19	Laundry	2,929	3,083	22,285	7.23	19
20	Administrator	2,080	2,080	48,000	23.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,055	4,470	58,899	13.18	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)	92,154	100,035	\$ 1,084,465 *	\$ 10.84	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	2,400	36
37	Medical Records Consultant	950	37
38	Nurse Consultant		38
39	Pharmacist Consultant	2,256	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	1,498	45
46	Other(specify)		46
47			47
48			48
49	TOTAL (lines 35 - 48)	\$ 7,104	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

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	
Janette Strobla	Admin	0	\$ 48,000	Workers' Compensation Insurance	\$ 21,430	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	10,197	Advertising: Employee Recruitment	254	
				FICA Taxes	82,962	Health Care Worker Background Check (Indicate # of checks performed _____)	70	
				Employee Health Insurance	95,431	Central Office Allocation	3,004	
				Employee Meals		Promotional Advertising	5,891	
				Illinois Municipal Retirement Fund (IMRF)*		Public Relations	5,223	
				Employee Hepatitis Vaccine	697	Dues and Subscriptions	5,735	
				Employee Benefits -	7,555	License and Fees	1,750	
				Employee Benefits - central office	25,146			
						Less: Public Relations Expense	(5,223)	
						Non-allowable advertising	(418)	
						Yellow page advertising	(5,891)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 48,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 243,418	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,395	
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	
								4,330
								220
							Seminar Expense	3,527
							Non Allowable	(10,967)
							Central Office Allocation	4,889
							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		\$ 144,019					
			0					
			0					
Legal Fees (Adjusted to zero)			45					
			0					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 144,064					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Heritage Manor-Mount Sterling# 0038273Report 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. \$ 47,633  
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. \$ 2,872
- (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.

Line	Code	Description	Amount	Balance
1				
2				
3				
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