

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: <u>0024836</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Heritage Fifty-Three</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/10</u> to <u>6/30/11</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>4016 9th Street</u> <u>Rock Island</u> <u>61201</u>																									
Number City Zip Code																									
County: <u>Rock Island</u>																									
Telephone Number: <u>309-786-6474</u> Fax # <u>309-786-9861</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Stacey Cary</u></td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>Associate Executive Director</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td colspan="2"></td><td>(Telephone) <u>()</u></td><td>Fax # <u>()</u></td></tr></table> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Stacey Cary</u>		Paid Preparer	(Title) <u>Associate Executive Director</u>		(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____				(Telephone) <u>()</u>	Fax # <u>()</u>				
Officer or Administrator of Provider	(Signed) _____				(Date) _____																				
	(Type or Print Name) <u>Stacey Cary</u>																								
Paid Preparer	(Title) <u>Associate Executive Director</u>																								
	(Signed) _____			(Date) _____																					
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
		(Telephone) <u>()</u>	Fax # <u>()</u>																						
Date of Initial License for Current Owners: <u>11/13/79</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>503c</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>503c</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.			☐ Trust			☐ Other _____	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>David Daughtery</u> Telephone Number: <u>309-786-6474</u>																									
Email Address: _____																									

Facility Name & ID Number Heritage Fifty-Three

0024836 Report Period Beginning: 7/1/10 Ending: 6/30/11

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	48	Intermediate/DD	48	17,520	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	48	TOTALS	48	17,520	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	17,216			17,216	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,216			17,216	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.26%

D. How many bed-hold days during this year were paid by the Department? 304 (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 11/13/79

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/13/79 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 _____

Medicare Intermediary No

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/11 Fiscal Year: 6/30/11

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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/10 Ending: 6/30/11
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 BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	147,101	3,289	4,160	154,550		154,550		154,550			1
2	Food Purchase		133,229		133,229	(21,063)	112,166	155	112,321			2
3	Housekeeping	34,978	30,301	59,914	125,193		125,193	570	125,763			3
4	Laundry		5,830		5,830		5,830		5,830			4
5	Heat and Other Utilities			83,147	83,147		83,147	900	84,047			5
6	Maintenance	20,579	54,527	3,132	78,238		78,238	5,021	83,259			6
7	Other (specify):*											7
8	TOTAL General Services	202,658	227,176	150,353	580,187	(21,063)	559,124	6,646	565,770			8
	B. Health Care and Programs											
9	Medical Director			4,725	4,725		4,725		4,725			9
10	Nursing and Medical Records	1,242,579	57,553	435	1,300,567		1,300,567	6,840	1,307,407			10
10a	Therapy											10a
11	Activities		1,114		1,114		1,114		1,114			11
12	Social Services	92,349			92,349		92,349		92,349			12
13	CNA Training	53,150	553		53,703		53,703		53,703			13
14	Program Transportation		15,770		15,770		15,770		15,770			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,388,078	74,990	5,160	1,468,228		1,468,228	6,840	1,475,068			16
	C. General Administration											
17	Administrative	64,622			64,622		64,622	169,676	234,298			17
18	Directors Fees											18
19	Professional Services							14,599	14,599			19
20	Dues, Fees, Subscriptions & Promotions			12,265	12,265		12,265	11,437	23,702			20
21	Clerical & General Office Expenses	9,974	6,899	8,670	25,543		25,543	4,492	30,035			21
22	Employee Benefits & Payroll Taxes			402,404	402,404	21,063	423,467	38,522	461,989			22
23	Inservice Training & Education							194	194			23
24	Travel and Seminar			99	99		99	859	958			24
25	Other Admin. Staff Transportation		1,352		1,352		1,352	1,291	2,643			25
26	Insurance-Prop.Liab.Malpractice			22,417	22,417		22,417	2,059	24,476			26
27	Other (specify):*											27
28	TOTAL General Administration	74,596	8,251	445,855	528,702	21,063	549,765	243,129	792,894			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,665,332	310,417	601,368	2,577,117		2,577,117	256,615	2,833,732			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			112,919	112,919		112,919	10,257	123,176			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							380	380			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			112,919	112,919		112,919	10,637	123,556			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,890	160,890		160,890		160,890			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			160,890	160,890		160,890		160,890			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,665,332	310,417	875,177	2,850,926		2,850,926	267,252	3,118,178			45

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF 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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

BHF 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 Amount	2 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)	267,252		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 267,252		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 267,252		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Fifty-Three

ID# 0024836

Report Period Beginning: 7/1/10

Ending: 6/30/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
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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	0		49

Summary A

6/30/11

[illegible]

Summary B

6/30/11

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None						

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	2	Food and Beverage	\$	ARCQCA	100.00%	\$ 155	\$ 155	1
2	V	3	Housekeeping		ARCQCA	100.00%	570	570	2
3	V	5	Utilities		ARCQCA	100.00%	900	900	3
4	V	6	Maintenance		ARCQCA	100.00%	5,021	5,021	4
5	V	19	Account/Consult		ARCQCA	100.00%	8,338	8,338	5
6	V	19	Legal Fees		ARCQCA	100.00%	6,261	6,261	6
7	V	17	Administration Salaries		ARCQCA	100.00%	169,676	169,676	7
8	V	20	Sub/Promotion/Printing		ARCQCA	100.00%	11,437	11,437	8
9	V	21	Office Supplies		ARCQCA	100.00%	3,546	3,546	9
10	V	21	Telephone		ARCQCA	100.00%	946	946	10
11	V	22	Employment Benefits		ARCQCA	100.00%	38,522	38,522	11
12	V	10	Medical/Hygiene Supplies		ARCQCA	100.00%	6,840	6,840	12
13	V	23	Staff Training		ARCQCA	100.00%	194	194	13
14	Total			\$			\$ 252,406	\$ * 252,406	14

* 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	24	Travel Seminar	\$	ARCQCA	100.00%	\$ 859	\$ 859	15
16	V	25	Other Administration, Staff Transportation		ARCQCA	100.00%	1,291	1,291	16
17	V	26	Insurance/Prof/Liability		ARCQCA	100.00%	2,059	2,059	17
18	V	32	Interest Mortgage		ARCQCA	100.00%	380	380	18
19	V	30	Depreciation		ARCQCA	100.00%	10,257	10,257	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 14,846	\$ * 14,846	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
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26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/10 Ending: 6/30/11

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 ☐

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

Name of Related Organization The Arc of the Quad Cities Area
Street Address 4016 9th Street
City / State / Zip Code Rock Island, IL 61201
Phone Number (309-786-6474
Fax Number (309-786-9861

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food and Beverage	The percent of budgeted	1,246,946	17 programs	\$ 585	\$	329,895	\$ 155	1
2	3	Housekeeping	Administrative costs	1,246,946	17 programs	2,156		329,895	570	2
3	5	Utilities	are to be allocated	1,246,946	17 programs	3,400		329,895	900	3
4	6	Maintenance	based on percentage	1,246,946	17 programs	18,977		329,895	5,021	4
5	19	Accountant/Consultant	of salary	1,246,946	17 programs	31,518		329,895	8,338	5
6	19	Legal Fees		1,246,946	17 programs	23,665		329,895	6,261	6
7	17	Administrative Salaries		1,246,946	17 programs	641,346		329,895	169,676	7
8	20	Sub/Promotion/Printing		1,246,946	17 programs	43,231		329,895	11,437	8
9	21	Other Expense		1,246,946	17 programs	13,403		329,895	3,546	9
10	21	Telephone		1,246,946	17 programs	3,575		329,895	946	10
11	22	Employee Benefits		1,246,946	17 programs	145,606		329,895	38,522	11
12	10	Medical/Hygiene Supplies		1,246,946	17 programs	25,855		329,895	6,840	12
13	23	Staff Training		1,246,946	17 programs	733		329,895	194	13
14	24	Travel Seminar		1,246,946	17 programs	3,246		329,895	859	14
15	25	Other Administration/Staff Transportation		1,246,946	17 programs	4,878		329,895	1,291	15
16	26	Insurance/Prof/Liability		1,246,946	17 programs	7,784		329,895	2,059	16
17	32	Interest Mortgage		1,246,946	17 programs	1,438		329,895	380	17
18	30	Depreciation		1,246,946	17 programs	38,771		329,895	10,257	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,010,167	\$		\$ 267,252	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	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.)

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 2010 report.				\$	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.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	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.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2006		8		
	2007		9		
	2008		10		
	2009		11		
	2010		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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Heritage Fifty-Three</u>	COUNTY	<u>Rock Island</u>
---------------	-----------------------------	--------	--------------------

FACILITY IDPH LICENSE NUMBER 0024836

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 2010 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 2010.

(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.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

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?

If YES, attach an explanation and 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 original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,376

B. General Construction Type: Exterior Brick Frame Steel Construction Number of Stories 1

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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: None

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	<u>DD Facility</u>	<u>196,020</u>	<u>1980</u>	<u>\$ 98,594</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	196,020		\$ 98,594	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	48		1980	1979	\$	\$	40	\$	\$	4
5			1998	1998	9,995		31.5			5
6										6
7										7
8										8
	Improvement Type**									
9	Shower Renovation			1985	92,597	4,644	20	4,644		101,885
10	Remodel Restrooms/Asphalt driveway			1986	6,987		20			6,987
11	Remodel Kitchen			1988	4,339					4,339
12	Asphalt Parking Lot/Remodel Kitchen #2			1989	17,029					17,029
13	Air Conditioning Kitchen			1992	6,808	216	31.5	216		7,178
14	Roof Repair, Asphalt, Remodeling			1993	15,650	497	31.5	497		10,319
15	Plumbing repairs, Sidewalk Ramp			1994	8,220	261	31.5	261		7,951
16	Roof and Hot Water System			1995	22,625	718	31.5	718		21,585
17	New Hot Water System			1996	50,449	1,602	31.5	1,602		18,262
18	Hot Water Continuation			1997	35,175	1,116	31.5	1,116		16,182
19	Hot Water Continuation			1997	4,202	133	31.5	133		2,863
20	Parking Lot Blacktop			1997	3,430	109	31.5	109		5,567
21	Shopper Driveway, Fire Alarm, Water Tank Tub			1998	35,520	1,128	31.5	1,128		12,996
22	Air/Fire Doors, Concrete Walks, Fuel Storage Tanks			1999	35,720	1,134	31.5	1,134		10,778
23	8 Power Doors			2000	9,485	301	31.5	301		2,860
24	Automatic Doors			2000	9,989	317	31.5	317		3,329
25	Concrete Walks/5 Areas			2000	2,550	81	31.5	81		769
26	Electrical For Auto Doors			2000	1,414	45	31.5	45		472
27	Electrical For Auto Doors			2000	1,365	43	31.5	43		452
28	Install Whirlpool Tub			2000	7,320	232	31.5	232		2,436
29	Bedroom Remodel/Salary Expense			2000	1,169	37	31.5	37		389
30	Twin Furnaces			2000	5,520	175	31.5	175		1,838
31	Blacktop Parking Lot			2001	3,960	126	31.5	126		1,196
32	Air Conditioning Repairs			2001	1,411	45	31.5	45		427
33	Install 8 Furnace Units			2001	10,400	330	31.5	330		3,135
34	Install 2 Air Conditioning Units			2001	4,250	135	31.5	135		1,282
35	Install Air Conditioning Units in Kitchen			2001	1,750	56	31.5	56		532
36	Electrical for Home Theatre			2001	530	17	31.5	17		161

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	Kick Plates/Door Guards	2001	\$ 900	\$ 29	31.5	\$ 29		\$ 275	37
38	Concrete Sidewalk/Ramp	2002	3,525	112	31.5	112		952	38
39	Install 2 Air Conditioning Units	2002	2,125	67	31.5	67		570	39
40	Install 5 Fire Doors	2002	643	20	31.5	20		170	40
41	Motor for Air Conditioning Unit	2002	500	16	31.5	16		136	41
42	Re-tile Floors	2002	18,750	595	31.5	595		5,058	42
43	Install 4 Wood Fire Doors	2002	546	17	31.5	17		145	43
44	Install Accordion Door	2002	4,495	143	31.5	143		1,072	44
45	Install Kitchen Hood Exhaust Fan	2002	2,114	67	31.5	67		570	45
46	Install 8 Countertop	2002	1,140	36	31.5	36		306	46
47	Install Sensory Room/Electrical Work	2002	1,606	51	31.5	51		433	47
48	Grease Trap	2004	3,640	116	31.5	116		870	48
49	Repairs to Automatic Doors	2004	2,805	89	31.5	89		668	49
50	Sewer Repairs	2004	3,537	112	31.5	112		840	50
51	Re-tile Kitchen Floor	2004	2,158	69	31.5	69		517	51
52	Sensory Room Electrical Work	2004	1,425	45	31.5	45		406	52
53	Install Air Conditioning Unit	2005	2,035	64	31.5	64		416	53
54	Update Fire System in Kitchen	2005	2,345	74	31.5	74		481	54
55	Install 29 Windows	2005	9,831	312	31.5	312		2,028	55
56	Install Whirlpool Tub	2005	2,898	92	31.5	92		598	56
57	Concrete Sidewalks	2005	3,650	116	31.5	116		754	57
58	Kitchen Cabinets	2005	4,705	149	31.5	149		969	58
59	Install Bathroom Tiles	2005	4,155	132	31.5	132		858	59
60	Install Lights/Electrical Work	2005	10,120	321	31.5	321		2,087	60
61	Install Ceiling Tiles/Drywall	2005	21,746	690	31.5	690		4,485	61
62	Building Renovations/RV	2006	62,226	1,975	31.5	1,975		10,863	62
63	Building Renovations/BV	2006	5,703	181	31.5	181		996	63
64	Install Fence around 4 Buildings	2006	9,630	306	31.5	306		1,683	64
65	Concrete Patios/RV	2006	5,450	173	31.5	173		952	65
66	Concrete Patios/ER	2006	6,100	194	31.5	194		1,067	66
67	Commercial Garbage Disposal/Main Kitchen	2006	1,571	50	31.5	50		275	67
68	Replace Mixing Valves	2006	2,773	88	31.5	88		484	68
69	Remodel PT Room	2006	13,283	422	31.5	422		2,321	69
70	TOTAL (lines 4 thru 69)		\$ 627,989	\$ 20,421		\$ 20,421		\$ 307,504	70

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

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 627,989	\$ 20,421		\$ 20,421	\$	\$ 307,504	1
2	Generator Repairs	2007	1,244	39	31.5	39		176	2
3	Install New Bedroom and Bathroom Doors	2007	6,611	210	31.5	210		945	3
4	Re-Tile Main Building Office/Hallways	2007	4,175	133	31.5	133		598	4
5	Sidewalk Repair between LW/RV	2007	1,200	38	31.5	38		171	5
6	New Fence around all buildings	2007	13,267	421	31.5	421		1,895	6
7	Install Fire Wall	2007	850	27	31.5	27		121	7
8	Build/Repair Walls	2007	1,400	44	31.5	44		198	8
9	Repair 3 doors BV	2007	680	22	31.5	22		99	9
10	Install Air Conditioning Unit in Kitchen	2007	2,900	92	31.5	92		414	10
11	Install 22 Windows LW	2007	8,360	265	31.5	265		1,193	11
12	Replace door and lock RV	2007	990	31	31.5	31		140	12
13	Clean Mixing Valves	2007	6,519	207	31.5	207		931	13
14	Install Kitchen Cabinets LW	2007	1,269	40	31.5	40		180	14
15	Repair Hot Water Heater RV	2007	1,578	50	31.5	50		225	15
16	Install 3 Soft Lite Windows	2007	1,259	40	31.5	40		180	16
17	Blacktop Front Circle Drive	2008	2,700	86	31.5	86		301	17
18	Repair Ducts in Main office building	2008	1,056	34	31.5	34		119	18
19	Install 16KW Generator	2008	13,200	419	31.5	419		1,467	19
20	Electrical Work/Main Office Building	2008	931	30	31.5	30		105	20
21	Wall/Plaster Repair Riverview	2008	1,125	36	31.5	36		126	21
22	Plumbing Work/Laundry facilities Riverview	2008	1,596	51	31.5	51		178	22
23	Clean Vents/Ducts Birchview	2008	965	31	31.5	31		108	23
24	Plumbing Work/Laundry & Sink hookup birchview	2008	1,023	32	31.5	32		112	24
25	RegROUT Showers Birchview	2008	1,000	32	31.5	32		112	25
26	Install 4 Windows Birchview	2008	1,440	46	31.5	46		161	26
27	Install Closet Doors Birchview	2008	1,912	61	31.5	61		213	27
28	Install 4 Double Dresser Birchview	2008	3,680	117	31.5	117		409	28
29	Install Light Fixtures Birchview	2008	2,450	78	31.5	78		273	29
30	New Roof Birchview	2008	17,460	554	31.5	554		1,939	30
31	Wall/Plaster Repair Lakewood Remodel	2008	2,440	77	31.5	77		270	31
32	Wall Protectors and Installation Lakewood Remodel	2008	6,398	203	31.5	203		711	32
33	Install Bathroom Countertop/Towel bar Lakewood Remodel	2008	1,590	50	31.5	50		175	33
34	TOTAL (lines 1 thru 33)		\$ 741,257	\$ 24,017		\$ 24,017	\$	\$ 321,749	34

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

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 741,257	\$ 24,017		\$ 24,017	\$	\$ 321,749	1
2	Tile/Grout work Kitchen Lakewood Remodel	2008	846	27	31.5	27		94	2
3	RegROUT Showers Lakewood Remodel	2008	2,000	63	31.5	63		221	3
4	New Window Blinds Lakewood Remodel	2008	5,041	160	31.5	160		560	4
5	Painting Lakewood Remodel	2008	1,905	60	31.5	60		210	5
6	Install Built-In Bedroom Dressers Lakewood Remodel	2008	3,640	116	31.5	116		406	6
7	Install 17 Windows Lakewood Remodel	2008	6,120	194	31.5	194		679	7
8	Install 8 Bathroom Mirrors Lakewood Remodel	2008	982	31	31.5	31		109	8
9	New Tile Flooring Lakewood	2008	2,267	72	31.5	72		252	9
10	Install New Bathroom Sinks/Drains Lakewood Remodel	2008	6,386	203	31.5	203		710	10
11	Install 16 Closet Doors Lakewood Remodel	2008	7,648	242	31.5	242		847	11
12	Laminate 5 Med Closet Doors Lakewood Remodel	2008	1,090	35	31.5	35		122	12
13	Relaminate doors Lakewood remodel	2008	4,270	136	31.5	136		476	13
14	Install New Doors/Frames Lakewood Remodel	2008	5,050	160	31.5	160		560	14
15	Electrical Work/Install Light Fixtures Lakewood Remodel	2008	15,892	505	31.5	505		1,767	15
16	Hardware supplies Lakewood Remodel	2008	1,933	61	31.5	61		214	16
17	Clean Vents/Ducts Lakewood	2008	965	31	31.5	31		108	17
18	Sidewalk Repair Lakewood	2008	7,050	224	31.5	224		784	18
19	New Roof on Riverview	2009	13,337	423	31.5	423		1,058	19
20	Install Handrails in Lakewood	2009	3,295	105	31.5	105		262	20
21	New Roof on Lakewood	2009	13,337	423	31.5	423		1,058	21
22	New Roof Main Building	2009	13,337	423	31.5	423		1,058	22
23	Concrete Work/Sidewalk Repair Main Building	2009	8,250	262	31.5	262		655	23
24	Underground Storage Tank	2009	1,134	36	31.5	36		90	24
25	Install new Ceiling Grid in Kitchen Main building	2009	735	23	31.5	23		58	25
26	Install Additional Fire System Main Building	2009	5,384	171	31.5	171		427	26
27	New Shed	2009	1,506	48	31.5	48		120	27
28	New Tile Floor Main Building	2009	498	16	31.5	16		40	28
29	Repair Air Conditioning Units	2009	1,692	54	31.5	54		135	29
30	Repair Gutters Main Building	2009	1,150	37	31.5	37		92	30
31	Build Block Wall Main building	2009	750	24	31.5	24		60	31
32	Install Circulating Pump Main Building	2009	1,466	47	31.5	47		117	32
33	Water Main Break Repairs Main Building	2009	11,806	375	31.5	375		937	33
34	TOTAL (lines 1 thru 33)		\$ 892,019	\$ 28,804		\$ 28,804	\$	\$ 336,035	34

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

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 12C, Carried Forward		\$ 892,019	\$ 28,804		\$ 28,804	\$	\$ 336,035	1
2	Plumbing repairs Main Building	2009	764	24	31.5	24		60	2
3	Install Generator/AMP Meter to Birchview	2009	11,000	349	31.5	349		873	3
4	Repairs to Fire Alarm Box in Birchview	2009	1,128	36	31.5	36		90	4
5	Install Vanities/Sinks in Bathrooms Birchview Remodel	2009	10,251	325	31.5	325		813	5
6	Built-In Closet and Dressers Birchview remodel	2009	18,516	588	31.5	588		1,470	6
7	Install Vertical Blinds Birchview Remodel	2009	3,390	108	31.5	108		270	7
8	Install New Lights Birchview Remodel	2009	9,907	315	31.5	315		787	8
9	Install Exterior Door Birchview Remodel	2009	1,286	41	31.5	41		102	9
10	Install/Re-laminate doors Birchview Remodel	2009	5,322	169	31.5	169		422	10
11	Install New Doors Locks Birchview Remodel	2009	1,349	43	31.5	43		107	11
12	Install 9 Mirrors Birhview Remodel	2009	1,140	36	31.5	36		90	12
13	Install Corner Boards/Cove Base Birchview Remodel	2009	4,353	138	31.5	138		345	13
14	Supplies for Birchview Remodel	2009	1,144	36	31.5	36		90	14
15	Concrete Work Birchview Remodel	2009	2,250	71	31.5	71		178	15
16	Kitchen Remodel/Install Backsplash Birchview Remodel	2009	5,909	188	31.5	188		470	16
17	Plumbing Work Birchview Remodel	2009	2,050	65	31.5	65		163	17
18	Baseboard Heat Birchview	2009	610	19	31.5	19		48	18
19	Electrical Work Birchview Remodel	2009	2,354	75	31.5	75		187	19
20	Concrete Pad for Generator H53	2010	1,700	54	31.5	54		81	20
21	Tile Showers area H53	2010	614	19	31.5	19		29	21
22	Generator for Birchview	2010	6,125	194	31.5	194		291	22
23	Electrical Work for Generator Birchview H53	2010	3,000	95	31.5	95		143	23
24	Siding Lakewood	2010	17,500	556	31.5	556		834	24
25	Compressors for Air Conditioning Units at Lakewood	2010	3,844	122	31.5	122		183	25
26	Concrete Sidewalks/Drive Apron at H53	2010	5,700	181	31.5	181		271	26
27	New Siding all buildings	2011	68,494	1,087	31.5	1,087		1,087	27
28	Engineering/Sprinkler System	2011	11,060	176	31.5	176		176	28
29	Architect Services	2011	1,000	16	31.5	16		16	29
30	Repair 6 doors LW	2011	1,058	17	31.5	17		17	30
31	Install 100 Gallon Hot Water Heater	2011	3,275	52	31.5	52		52	31
32	Install 3 Air Conditioning Units	2011	5,264	84	31.5	84		84	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,103,376	\$ 34,083		\$ 34,083	\$	\$ 345,864	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$563,186	\$77,265	\$77,265	\$	10	\$431,984	71
72	Current Year Purchases	46,275	4,628	4,628		10	4,628	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$609,461	\$81,893	\$81,893	\$		\$436,612	75

D. Vehicle Costs. (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	Patient Care	2008 Chevy Uplander	2008	\$36,000	\$7,200	\$7,200	\$	5	\$25,200
77									
78									
79									
80	TOTALS			\$36,000	\$7,200	\$7,200	\$		\$25,200

E. Summary of Care-Related Assets				1	2
		Reference			Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$1,847,431
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$123,176
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$123,176
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$807,676

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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 Original Lease Date	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

**

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: \$
- Description:

(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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

55

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed			Contract	Total
1	Community College Tuition	\$	\$			\$	\$
2	Books and Supplies	55	498				553
3	Classroom Wages (a)	468	10,177				10,645
4	Clinical Wages (b)	822	14,803				15,625
5	In-House Trainer Wages (c)	2,688	24,192				26,880
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$ 4,033	\$ 49,670			\$	\$ 53,703
10	SUM OF line 9, col. 1 and 2 (e)	\$ 53,703					

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	20

(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 CNA 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 CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs 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 CNAs.

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

	1	2	3	4	5	6	7	8		
	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	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 CNAs, who help with the above activities should not be listed on this schedule.

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	\$932,496	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	702,072		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,503		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$1,637,071	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	98,594		13
14	Buildings, at Historical Cost	1,103,376		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	645,461		16
17	Accumulated Depreciation (book methods)	(807,676)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$1,039,755	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$2,676,826	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$91,462	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	397,140		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	81,804		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$570,406	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$570,406	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$2,106,420	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$2,676,826	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$1,939,868	1
2	Restatements (describe):	(30,138)	2
3	Fixed Asset Reclassification		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$1,909,730	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	196,690	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$196,690	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)	\$2,106,420	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,872,505	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,872,505	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education	482	9
10	Other Government Grants	8,356	10
11	CNA Training Reimbursements	26,491	11
12	Gift and Coffee Shop	2,731	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,524	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	28,879	21
22	Laundry	17,107	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 88,570	23
	D. Non-Operating Revenue		
24	Contributions	81,469	24
25	Interest and Other Investment Income***	5,072	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 86,541	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)	\$ 3,047,616	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	580,187	31
32	Health Care	1,468,228	32
33	General Administration	528,702	33
	B. Capital Expense		
34	Ownership	112,919	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	160,890	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,850,926	40
41	Income before Income Taxes (line 30 minus line 40)**	196,690	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 196,690	43

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

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

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

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

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		1,618	\$ 39,225	\$ 24.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses		14,577	257,097	17.64	4
5	CNAs & Orderlies					5
6	CNA Trainees		2,521	26,270	10.42	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor		2,080	29,594	14.23	13
14	Head Cook					14
15	Cook Helpers/Assistants		12,586	117,507	9.34	15
16	Dishwashers					16
17	Maintenance Workers		989	20,579	20.81	17
18	Housekeepers		3,662	34,978	9.55	18
19	Laundry					19
20	Administrator		2,496	64,622	25.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager		420	5,637	13.42	23
24	Clerical		324	4,337	13.39	24
25	Vocational Instruction					25
26	Academic Instruction		1,319	26,880	20.38	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)		5,596	92,349	16.50	28
29	Resident Services Coordinator		9,904	148,257	14.97	29
30	Habilitation Aides (DD Homes)		76,583	798,000	10.42	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		134,675	\$ 1,665,332 *	\$ 12.37	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	83	\$ 4,160	L1C3	35
36	Medical Director				36
37	Medical Records Consultant	Annual	4,725	L9C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	9	435	L10C3	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	92	\$ 9,320		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberHeritage Fifty-Three# 0024836Report Period Beginning: 7/1/10Ending: 6/30/11Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Susan Smith

Administrator

\$ 53,856

Julie Williams

Assoc. Ex. Dir.

10,766

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 64,622

B. Administrative - Other

Description

Amount

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

\$

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$5,000, attach copy of invoices.)

\$

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 52,060

Unemployment Compensation Insurance

6,053

FICA Taxes

138,803

Employee Health Insurance

78,736

Employee Meals

21,063

Illinois Municipal Retirement Fund (IMRF)*

Pension Expense Employer Paid

120,715

Disability Insurance

2,751

Group Term Insurance

2,702

Admin Fringe Benefits from schedule VIII line 11 c9

38,522

Immunization Costs

585

TOTAL (agree to Schedule V, line 22, col.8)

\$ 461,989

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 4,225

Advertising: Employee Recruitment

9,729

Health Care Worker Background Check

(Indicate # of checks performed 0)

0

Patient Background Checks

62

Arc of IL and US Dues

3,800

Staff Awards and Promotions, Advocacy

4,067

Subscriptions

151

Direct Deposit Fees

800

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 23,702

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

958

Seminar Expense

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 958

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2) Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

(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?

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$None

Line

(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?

YESXNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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 during this cost report period.

\$160,890

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, 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.

\$21,063

Has any meal income been offset against related costs?

No

Indicate the amount. \$None

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

Yes

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. \$None

c. What percent of all travel expense relates to transportation of nurses and patients?

No

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?

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period. \$None

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name: McGladrey and Pullen LLP

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19) If total legal fees are in excess of \$5,000, 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.