

		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>0038620</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Heritage Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</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>5888 North Ridge Avenue</u> <u>Chicago</u> <u>60660</u> Number City Zip Code																											
County: <u>Cook</u>																											
Telephone Number: <u>(773) 769-2626</u> Fax # <u>(773) 769-2650</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>11/1/1992</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____ (Date) _____</td></tr><tr><td>(Type or Print Name) <u>DAN SHABAT</u></td></tr><tr><td>(Title) <u>OWNER</u></td></tr><tr><td>(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>DAN SHABAT</u>	(Title) <u>OWNER</u>	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____																			
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	(Title) <u>OWNER</u>																										
	(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____																										
Type of Ownership:		<table><tr><td rowspan="5">Paid Preparer</td><td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td></tr><tr><td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td></tr><tr><td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td></tr><tr><td colspan="2">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</td></tr><tr><td colspan="2"></td></tr></table>	Paid Preparer	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>	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																				
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	☐ Other	_____																									
In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____																											

Facility Name & ID Number Heritage Nursing Home

0038620 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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>44</u>	Skilled (SNF)	<u>44</u>	<u>16,060</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>84</u>	Intermediate (ICF)	<u>84</u>	<u>30,660</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>128</u>	TOTALS	<u>128</u>	<u>46,720</u>	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	<u>6,963</u>	<u>166</u>	<u>1,241</u>	<u>8,370</u>	8
9	SNF/PED					9
10	ICF	<u>32,132</u>	<u>436</u>		<u>32,568</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,095</u>	<u>602</u>	<u>1,241</u>	<u>40,938</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.62%

D. How many bed-hold days during this year were paid by the Department?
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 07/01/02

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/01/02 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 21 and days of care provided 1,241

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Heritage Nursing Home # 0038620 Report Period Beginning: 01/01/2011 Ending: 12/31/2011
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	212,661	16,979	5,472	235,112		235,112		235,112			1
2	Food Purchase		200,373		200,373	(25,733)	174,640	(782)	173,858			2
3	Housekeeping	130,403	19,940		150,343		150,343		150,343			3
4	Laundry	35,814	10,102	1,422	47,338		47,338		47,338			4
5	Heat and Other Utilities			101,504	101,504		101,504		101,504			5
6	Maintenance	38,301	7,952	31,274	77,527		77,527		77,527			6
7	Other (specify):* Security Salary	11,759		7,817	19,576		19,576		19,576			7
8	TOTAL General Services	428,938	255,346	147,489	831,773	(25,733)	806,040	(782)	805,258			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,316,317	55,689	17,480	1,389,486		1,389,486		1,389,486			10
10a	Therapy		1,555	540	2,095		2,095		2,095			10a
11	Activities	89,345	4,560	8,233	102,138		102,138		102,138			11
12	Social Services	112,415		4,324	116,739		116,739		116,739			12
13	CNA Training											13
14	Program Transportation			172	172		172		172			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,518,077	61,804	42,749	1,622,630		1,622,630		1,622,630			16
	C. General Administration											
17	Administrative	408,804		317,500	726,304		726,304	(254,119)	472,185			17
18	Directors Fees											18
19	Professional Services			42,963	42,963		42,963	6,185	49,148			19
20	Dues, Fees, Subscriptions & Promotions			33,389	33,389		33,389	(16,358)	17,031			20
21	Clerical & General Office Expenses	74,302	7,538	12,274	94,114		94,114	(2,207)	91,907			21
22	Employee Benefits & Payroll Taxes			350,914	350,914	25,733	376,647		376,647			22
23	Inservice Training & Education			1,840	1,840		1,840		1,840			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			1,323	1,323		1,323	(1,323)				25
26	Insurance-Prop.Liab.Malpractice			584	584		584	100,380	100,964			26
27	Other (specify):*							3,889	3,889			27
28	TOTAL General Administration	483,106	7,538	760,787	1,251,431	25,733	1,277,164	(163,553)	1,113,611			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,430,121	324,688	951,025	3,705,834		3,705,834	(164,335)	3,541,499			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

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	5,472
	REPAIRS & MAINTENANCE		0
			0
			5,472
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		1,422
			0
			1,422
5	HEAT & OTHER UTILITIES		
	GAS HEAT		44,111
	ELECTRICITY		40,038
	WATER		17,355
	CABLE TV - LOBBY		0
			0
			101,504
6	MAINTENANCE		
	GROUPS MAINTENANCE		1,125
	PAINTING & DECORATING		63
	BUILDING REPAIRS		450
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		21,771
	ELEVATOR MAINTENANCE & REPAIR		5,082
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		2,783
	FIRE SERVICE		0
			0
			0
			0
			0
			31,274
7	OTHER		
	SCAVENGER		7,817
	SECURITY SERVICE		0
			0
			0
			7,817
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000
			12,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	12,188
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B 46-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,960
	PHARMACY CONSULTANT	XVIII B 39-2	3,332
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			17,480
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		315
	SPEECH THERAPY SERVICES		225
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			540
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		3,258
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,975
			0
			8,233
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	4,324
			4,324
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	172
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	317,500
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	11,673
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	31,290
		0
		42,963
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	12,118
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	800
	DUES & SUBSCRIPTIONS XIX F	10,522
	LICENSES & PERMITS XIX F	1,055
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	250
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	3,190
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	140
	PATIENT FINGERPRINTS/BACKGROUND CHEC XIX F	5,314
		33,389
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	175
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,207
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	9,892
	MESSENGER SERVICE	0
		0
		12,274

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	176,345
	UNEMPLOYMENT COMPENSATION XIX D	22,449
	WORKERS COMPENSATION INSURANC XIX D	33,678
	HOSPITALIZATION INSURANCE XIX D	100,977
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	13,997
	CHICAGO HEAD TAX XIX D	3,468
		0
		350,914
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,840
		1,840
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	1,323
		1,323
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	584
		584
		584
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER 951,025

Heritage Nursing Home
SCHEDULES
12/31/2011

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	200,373
LESS SALES TAX	(782)
NET FOOD	199,591
TOTAL PATIENT CENSUS	40,938
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	122,814
ADD # EMPLOYEE MEALS/DAY	50
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	18,250
PATIENT MEALS	122,814
ADD EMPLOYEE MEALS	18,250
TOTAL MEALS/YEAR	141,064
NET FOOD	199,591
DIVIDE TOTAL MEALS/YEAR	141,064
COST PER MEAL	1.41
TIME EMPLOYEE MEALS	18,250
EMPLOYEE MEAL RECLASSIFICATION	25,733
	=====

PROFESSIONAL FEES
PAGE 21 XIX. C.

MEDIFAX EDI	DATA PROCESSING	179
MDI TECHNOLOGY	DATA PROCESSING	7,419
IVANS	DATA PROCESSING	1183
LIFE CARE SOFTWARE SOLUTIONS	DATA PROCESSING	2892
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	14,020
OSTROW REISEN BERK ABRAMS	ACCOUNTING	2,324
STEVEN BRUEGGEMAN	ACCOUNTING	6,100
ASHMAN & STEIN	LEGAL	1,786
KEMPSTER, KELLER, LENZ-CALVO	IMMIGRATION LEGAL	2,910
SKIDELSKY & ASSOCIATES	REAL ESTATE TAX LEGAL	185
MUCH SHELIST	LEGAL	515
RICHARD PEELO	MEDICARE COST REPORT	2,750
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULTANT	700
	PROFESSIONAL FEES	42,963
		=====
MUCH SHELIST - DISALLOWED LEGAL	SEE PAGE 5A LINE 3	(515)

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			41,971	41,971		41,971	58,071	100,042			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,874	10,874		10,874	181,129	192,003			32
33	Real Estate Taxes							116,285	116,285			33
34	Rent-Facility & Grounds			600,331	600,331		600,331	(600,331)				34
35	Rent-Equipment & Vehicles			427	427		427		427			35
36	Other (specify):*							14,774	14,774			36
37	TOTAL Ownership			653,603	653,603		653,603	(230,072)	423,531			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		60,884	144,449	205,333		205,333		205,333			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,080	70,080		70,080		70,080			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		60,884	214,529	275,413		275,413		275,413			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,430,121	385,572	1,819,157	4,634,850		4,634,850	(394,407)	4,240,443			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	(681)	30		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	(782)	2		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	(250)	20		17
18	Fines and Penalties	(2,207)	21		18
19	Entertainment				19
20	Contributions	(3,990)	20		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	(12,118)	20		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	(39,217)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (59,245)		\$	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)	(335,162)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (335,162)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (394,407)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Nursing Home

ID# 0038620

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	1/2 ASST ADMIN SALARY->MARKETING	\$ (37,379)	17	1
2	MARKETING TRAVEL	(1,323)	25	2
3	DISALLOWED LEGAL	(515)	19	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				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	(39,217)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Nursing Home # 0038620 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(782)	0	0	0	0	0	0	0	0	0	0	(782)	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	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(782)	0	0	0	0	0	0	0	0	0	0	(782)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(37,379)	0	(216,740)	0	0	0	0	0	0	0	0	(254,119)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(515)	6,700	0	0	0	0	0	0	0	0	0	6,185	19
20	Fees, Subscriptions & Promotions	(16,358)	0	0	0	0	0	0	0	0	0	0	(16,358)	20
21	Clerical & General Office Expenses	(2,207)	0	0	0	0	0	0	0	0	0	0	(2,207)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,323)	0	0	0	0	0	0	0	0	0	0	(1,323)	25
26	Insurance-Prop.Liab.Malpractice	0	100,380	0	0	0	0	0	0	0	0	0	100,380	26
27	Other (specify):*	0	0	3,889	0	0	0	0	0	0	0	0	3,889	27
28	TOTAL General Administration	(57,782)	107,080	(212,851)	0	0	0	0	0	0	0	0	(163,553)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(58,564)	107,080	(212,851)	0	0	0	0	0	0	0	0	(164,335)	29

Summary B

12/31/2011

[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
Dan Shabat	100%	Waterford Nursing & Rehabilitation Centre	Chicago	Heritage Healthcare Centre LLC		Real Estate Rental
				Pharmore Drugs LLC		Drug Co
				Lifescan Laboratory Inc		Lab Co
				Pro Health Care Inc		Mgmt Co
				SFMA Inc		Mgmt Co

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	34	Rent	\$ 600,331	Heritage Healthcare Centre LLC	100.00%	\$	\$ (600,331)	1
2	V	32	Interest		" "		177,307	177,307	2
3	V	19	Accounting Fees		" "		6,700	6,700	3
4	V	26	Property Insurance		" "		100,380	100,380	4
5	V	33	R E Taxes		" "		116,285	116,285	5
6	V	30	SL Depreciation		" "		58,752	58,752	6
7	V	32	Amortization Loan Fees		" "		3,822	3,822	7
8	V	36	MIP Expense		" "		14,774	14,774	8
9	V				" "				9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 600,331			\$ 478,020	\$ * (122,311)	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	17	Management Fees	\$ 312,000	SFMA, INC		\$	(312,000)	15
16	V	17	Dan Shabat Comp		" "		97,500	97,500	16
17	V	27	Admin Benefits		" "		3,729	3,729	17
18	V								18
19	V								19
20	V	17	Management Fees	5,500	Pro Health Care Inc			(5,500)	20
21	V	17	Salary - Stan Aron		" "		3,260	3,260	21
22	V	27	Payroll Taxes		" "		160	160	22
23	V								23
24	V								24
25	V	10	In House Drugs	57,116	Pharmore Drugs LLC		57,116		25
26	V	39	Exp - Drugs	5,118	" "		5,118		26
27	V	10	Pharmacy Consultant	3,332	" "		3,332		27
28	V								28
29	V								29
30	V	39	Exp - Laboratory	1,551	Lifescan Laboratory Inc		1,551		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			\$ 384,617			\$ 171,766	\$ * (212,851)	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
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

Facility Name & ID Number Heritage Nursing Home # 0038620 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	Dan Shabat	Owner	Administrative	100.00	See Attached	20	33.00	Alloc Salary	\$	17-7	1
2	Stan Aron		Administrative	0.00	See Attached	1	2.44	Alloc Salary		17-7	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 Nursing Home # 0038620 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 SFMA INC
Street Address 7520 North Skokie Blvd
City / State / Zip Code Skokie, IL 60077
Phone Number (847) 982-1195
Fax Number (847) 982-0991

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Dan Shabat Comp	Avg Hours Worked	40	2	\$ 195,000	\$ 195,000	20	\$ 97,500	1
2	27	Admin Benefits	" "	40	2	7,458		20	3,729	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	TOTALS					\$ 202,458	\$ 195,000		\$ 101,229	25

Facility Name & ID Number Heritage Nursing Home # 0038620 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 Pro Health Care Inc C/O FR & R
Street Address 111 Pfingsten Road
City / State / Zip Code Deerfield, IL 60115
Phone Number (847) 236-1111
Fax Number (847) 236-1155

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salary - Stan Aron	Ave Hours Worked	41	4	\$ 133,640	\$ 133,640	1	\$ 3,260	1
2	27	Payroll Taxes	" "	41	4	6,566		1	160	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	TOTALS					\$ 140,206	\$ 133,640		\$ 3,420	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	RELATED PARTY-Heritage Healthcare Centre LLC													
2	Heartland Bank		X	Mortgage	\$18,972.78	08/25/06	3,164,500	2,931,893	09/2036	6.0000	177,307		2	
3	Loan Fees		X	Amortized over life of loan			114,655	94,271			3,822		3	
4													4	
5	Lexus Financial		X	Auto Loan	\$803.75	10/13/10	26,804	16,875	10/27/13	4.9000	1,057		5	
	Working Capital													
6	Line of Credit		X	Working Capital	DEMAND			768,804		PRIME+	9,817		6	
7													7	
8													8	
9	TOTAL Facility Related				\$19,776.53		\$ 3,305,959	\$ 3,811,843			\$ 192,003		9	
	B. Non-Facility Related*													
10													10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$	\$			\$		14	
15	TOTALS (line 9+line14)						\$ 3,305,959	\$ 3,811,843			\$ 192,003		15	

16)

Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ 14,774

Line # 36

* 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.			\$ 107,528	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.)			\$ 110,253	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 2,725	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 113,560	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.			\$ 116,285	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2006	152,348	8	
	2007	133,381	9	
	2008	134,720	10	
	2009	104,396	11	
	2010	110,253	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				
THE PAYMENT ON LINE 2 APPLIES TO THE 2010 TAX BILL.				
	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2010	\$		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.**

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Heritage Nursing Home</u>	COUNTY	<u>Cook</u>
---------------	------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0038620

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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</u> <u>Applicable to</u> <u>Nursing Home</u>
1. 14-05-306-016-0000	NURSING HOME	\$ 110,252.62	\$ 110,252.62
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 110,252.62	\$ 110,252.62

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 X NO

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:

84,000

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

3

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).

N/A

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	RELATED PARTY - Heritage Healthcare Centre, LLC		1991	\$ 105,600	1
2					2
3	TOTALS			\$ 105,600	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	RELATED PARTY-Heritage Healthcare Centre, LLC				\$	\$		\$	\$	\$	4
5	128		1991	1971	1,878,400	48,164	39	48,164		1,009,439	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY-Heritage Healthcare Centre, LLC										9
10	Heritage Nursing Center Inc		1983		6,069		15			6,069	10
11	Heritage Nursing Center Inc		1984		2,054		10			2,054	11
12	Heritage Nursing Center Inc		1985		3,700		10			3,700	12
13	Heritage Nursing Center Inc		1985		5,594		10			5,594	13
14	Heritage Nursing Center Inc		1986		5,000		10			5,000	14
15	Heritage Nursing Center Inc		1987		2,250		10			2,250	15
16	Heritage Nursing Center Inc		1988		6,084		10			6,084	16
17	Heritage Nursing Center Inc		1990		4,919		10			4,919	17
18	Heritage Nursing Center Inc		1991		118,564		10			118,564	18
19	Heritage Nursing Center Inc		1991		6,809		10			6,809	19
20	Heritage Nursing Center Inc		1992		12,811		10			12,811	20
21	Heritage Nursing Center Inc		1992		8,947		10			8,947	21
22	1st, 2nd & 3rd Floor New nurses station, chart racks, cabinet & 2 doors, new cabinets, counter top, sink										22
23	& faucet in 1st fl nurse station med room & utility room		2007		43,252	4,326	10	4,326		19,548	23
24	5 flat grilles with borders		2007		392	78	5	78		346	24
25	Paint/seal building; patch/seal coat/stripe parking lot		2007		21,260	1,418	15	1,418		6,142	25
26	Replacement of door handles/locksets/door protector sleeve		2007		14,908	2,982	5	2,982		12,920	26
27	Reception area-door,glass wall,countertop,carpeting,painting		2010		13,340	1,334	10	1,334		2,223	27
28	12' Cast Iron underground pipe - kitchen area		2010		4,500	450	10	450		713	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											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

Facility Name & ID Number Heritage Nursing Home

0038620

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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	FACILITY:		\$	\$		\$	\$	\$	37
38	Various	1993	22,988		15			22,988	38
39	Various	1994	22,000	1,000	20	1,000		19,168	39
40	Various	1994	19,790	100	15		(100)	19,790	40
41	Various	1995	3,300		15			3,300	41
42	Various	1995	1,640		10			1,640	42
43	Various	1995	59,530	2,978	20	2,978		48,759	43
44	Various	1996	83,406	4,170	20	4,170		65,783	44
45	Various	1997	4,851		7			4,851	45
46	Various	1997	25,361	1,268	20	1,268		18,863	46
47	Various	2000	5,357	43	20	43		4,987	47
48	Various	2002	13,354	1,335	10	1,335		13,011	48
49	Various	2004	33,850	3,385	10	3,385		24,259	49
50									50
51	Wallcoverings and Flooring	2005	85,222	5,681	15	5,681		34,506	51
52	Install Water Coils	2005	21,675		5			21,675	52
53	Paint and Custom Replacement Baseboard Covers	2007	1,803	361	5	361		1,503	53
54	Nurses Station	2007	3,790	379	10	379		1,579	54
55	1st, 2nd and 3rd Floor Nurses Stations	2007	10,000	1,000	10	1,000		4,333	55
56	Nurses Station Sprinkler Head Improvements	2007	2,207	221	10	221		919	56
57	Barker Metalcraft	2008	1,803	180	10	180		646	57
58	Doors Done Right - Door, Frame and Heavy Duty Closer	2008	2,181	145	15	145		521	58
59	Walkin Cooler/Freezer	2008	20,505	4,101	20	4,101		13,328	59
60	Install Walkin Cooler/Freezer	2009	10,791	2,159	5	2,159		6,475	60
61	Cable Hardware & installation Resident & Day Rooms	2009	10,850	1,085	10	1,085		3,165	61
62	Elevator Door Operator, Restrictor & Sensor	2009	8,675	315	27.5	315		946	62
63	Fire Alarm & Sprinkler System Upgrades	2009	3,202	117	27.5	117		340	63
64	Hot Water Coil & Boiler Gas Valve & Pilot Assembly	2009	5,693	206	27.5	206		487	64
65	"LG" Mini Split System For Kitchen	2009	5,029	183	27.5	183		457	65
66	Replace Front East Gate	2009	1,950	71	27.5	71		177	66
67	Steel Frame & Door	2009	1,891	69	27.5	69		155	67
68	Electrical Work & Motors for Rooftop Exhaust Fans	2009	4,080	149	27.5	149		363	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,655,627	\$ 89,453		\$ 89,353	\$ (100)	\$ 1,573,106	70

**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	\$30,394	\$3,723	\$3,723	\$	5-10 yrs	\$22,744	71
72	Current Year Purchases	2,647	2,647	265	(2,382)	5 yrs	265	72
73	Fully Depreciated Assets	275,206				5-10 yrs	275,206	73
74	RELATED PARTY-Heritage Healthcare Centre, LLC	247,414				5-10 yrs	247,414	74
75	TOTALS	\$555,661	\$6,370	\$3,988	\$(2,382)		\$545,629	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	ADMINISTRATIVE	2011 LEXUS 4D	2010	\$26,804	\$4,900	\$6,701	\$1,801	4 yrs	\$10,052	76
77										77
78										78
79										79
80	TOTALS			\$26,804	\$4,900	\$6,701	\$1,801		\$10,052	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,343,692	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$100,723	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$100,042	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(681)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,128,787	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-related partry
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: \$427
- Description: Postage meter rental

(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.

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

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

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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

- (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.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			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	39-3	hrs	\$		\$ 46,807	\$		\$ 46,807	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			36,749			36,749	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			60,494			60,494	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				57,116		57,116	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	39-3				399			399	12
13	Other (specify): Lab, Med Supplies	39-2					3,768		3,768	13
14	TOTAL			\$		\$ 144,449	\$ 60,884		\$ 205,333	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,723	\$ 61,346	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (325,000))	1,913,095	1,913,095	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,329	68,881	6
7	Other Prepaid Expenses	2,446	2,446	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Loans & Advances	2,570	2,570	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,945,163	\$ 2,048,338	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,600	13
14	Buildings, at Historical Cost		2,170,209	14
15	Leasehold Improvements, at Historical Cost	496,774	496,774	15
16	Equipment, at Historical Cost	335,054	626,305	16
17	Accumulated Depreciation (book methods)	(655,310)	(2,141,353)	17
18	Deferred Charges		94,271	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		696,205	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Security Deposit	5,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 181,518	\$ 2,048,011	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,126,681	\$ 4,096,349	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 339,153	\$ 381,594	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,098	6,098	28
29	Short-Term Notes Payable	777,823	831,030	29
30	Accrued Salaries Payable	117,669	117,669	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,929	15,929	31
32	Accrued Real Estate Taxes(Sch.IX-B)		113,560	32
33	Accrued Interest Payable		14,659	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Parties</u>	160,411	543,523	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,417,083	\$ 2,024,062	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,856	7,856	39
40	Mortgage Payable		2,878,686	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)	\$ 7,856	\$ 2,886,542	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,424,939	\$ 4,910,604	46
47	TOTAL EQUITY(page 18, line 24)	\$ 701,742	\$ (814,255)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,126,681	\$ 4,096,349	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 759,001	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4	Post-closing equity reclassification	(300,000)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 459,000	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	242,742	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)	\$ 242,742	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)	\$ 701,742	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	\$ 4,880,364	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,880,364	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		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 4,880,364	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	831,773	31
32	Health Care	1,622,630	32
33	General Administration	1,251,431	33
	B. Capital Expense		
34	Ownership	653,603	34
	C. Ancillary Expense		
35	Special Cost Centers	205,333	35
36	Provider Participation Fee	70,080	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,634,850	40
41	Income before Income Taxes (line 30 minus line 40)**	245,514	41
42	Income Taxes	(2,772)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 242,742	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** 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	1,757	3,761	\$ 77,977	\$ 20.73	1
2	Assistant Director of Nursing	1,821	2,086	62,967	30.19	2
3	Registered Nurses	11,932	12,644	317,463	25.11	3
4	Licensed Practical Nurses	11,358	12,140	285,858	23.55	4
5	CNAs & Orderlies	43,382	48,386	504,849	10.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,043	8,361	89,345	10.69	10
11	Social Service Workers	7,033	7,706	112,415	14.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,731	18,267	212,661	11.64	15
16	Dishwashers					16
17	Maintenance Workers	1,922	2,237	38,301	17.12	17
18	Housekeepers	11,262	12,892	130,403	10.12	18
19	Laundry	3,454	3,863	35,814	9.27	19
20	Administrator	1,905	2,134	71,432	33.47	20
21	Assistant Administrator	1,893	2,196	74,757	34.04	21
22	Other Administrative	1,946	2,130	262,615	123.29	22
23	Office Manager					23
24	Clerical	5,725	6,212	74,302	11.96	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	1,778	2,007	19,895	9.91	31
32	Other Health Care MDS	1,936	2,146	47,308	22.04	32
33	Other(specify) Security	1,213	1,235	11,759	9.52	33
34	TOTAL (lines 1 - 33)	133,091	150,403	\$ 2,430,121 *	\$ 16.16	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	M	\$ 5,472	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	1,960	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,332	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	4,975	11-3	44
45	Social Service Consultant	E	4,324	12-3	45
46	Other(specify) Psycho-social	S	0	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 32,063		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	319	12,188	10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)	319	\$ 12,188		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberHeritage Nursing Home# 0038620Report Period Beginning:01/01/2011Ending:12/31/2011Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas Dean	Administrator		\$ 71,432
Sylvia Herlihy	Exec Director		262,615
Emily Ulrich	Asst Admin		74,757
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 408,804

B. Administrative - Other

Description	Amount
Management Fees - SFMA	\$ 312,000
Management Fees - Pro Health	5,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		\$
SEE SCHEDULE ATTACHED		42,963
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 42,963

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 33,678
Unemployment Compensation Insurance	22,449
FICA Taxes	176,345
Employee Health Insurance	100,977
Employee Meals	25,733
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	0
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	13,997
CHICAGO HEAD TAX	3,468
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	

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	\$
Advertising: Employee Recruitment	0
Health Care Worker Background Check (Indicate # of checks performed 14)	140
Patient Background Checks 11	110
TRUST/FRANCHISE/CONTRIB/ETC	4,240
MARKETING/ADV/PROMO	12,118
LICENSES/DUES/SUBSCRIPTIONS	11,577
RESIDENT FINGERPRINTS	5,204
TRUST/FRANCHISE/CONTRIB/ETC	(4,240)
Less: Public Relations Expense	(0)
Non-allowable advertising	(12,118)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$

* 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?

YES

If YES, give association name and amount.

ICLTC \$9,578
- (3)

Did the nursing home make political contributions or payments to a political action organization?

YES

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?

10 YR
- (6)

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

\$ 3,194

Line 10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

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

YES

X

NO

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

Heritage Healthcare Center License #38620 Through 11/01/1992
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 70,080

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, 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.

\$ 25,733

Has any meal income been offset against related costs?

N/A

Indicate the amount.

\$
- (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?

5%

d. Have vehicle usage logs been maintained?

NO

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

NO

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?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (17)

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

NO

Firm Name:
- (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.