

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0024836

Facility Name: Heritage Fifty-Three

Address: 4601 53rd Street Moline 61265
 Number City Zip Code

County: Rock Island

Telephone Number: (309) 786-6474 **Fax #** (309) 786-9861

HFS ID Number: 362615996001

Date of Initial License for Current Owners: 11/13/79

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>503c</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: David Daugherty **Telephone Number:** (309) 786-6474

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/05 to 6/30/06 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.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Jane O'Melia</u>	
	(Title) <u>First Associate Executive Director</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

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

Facility Name & ID Number Heritage Fifty-Three

0024836 Report Period Beginning: 7/1/05 Ending: 6/30/06

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 48

	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	<u>48</u>	Intermediate/DD	<u>48</u>	<u>17,520</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>48</u>	TOTALS	<u>48</u>	<u>17,520</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD	<u>17,366</u>			<u>17,366</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>17,366</u>			<u>17,366</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.12%

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

154 (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 _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/06 Fiscal Year: 6/30/06

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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/05 Ending: 6/30/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	161,803	4,964	3,579	170,346		170,346		170,346		1
2	Food Purchase		131,926		131,926	(25,895)	106,031	308	106,339		2
3	Housekeeping	56,450	17,310	8,632	82,392		82,392	112	82,504		3
4	Laundry		15,033		15,033		15,033		15,033		4
5	Heat and Other Utilities			86,781	86,781		86,781	2,061	88,842		5
6	Maintenance	21,564	39,504	6,933	68,001		68,001	4,642	72,643		6
7	Other (specify):*										7
8	TOTAL General Services	239,817	208,737	105,925	554,479	(25,895)	528,584	7,123	535,707		8
	B. Health Care and Programs										
9	Medical Director			4,725	4,725		4,725		4,725		9
10	Nursing and Medical Records	1,230,160	46,404	614	1,277,178		1,277,178	1,026	1,278,204		10
10a	Therapy										10a
11	Activities		3,654		3,654		3,654		3,654		11
12	Social Services	53,212			53,212		53,212		53,212		12
13	CNA Training	46,467	275		46,742		46,742		46,742		13
14	Program Transportation		15,370		15,370		15,370		15,370		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,329,839	65,703	5,339	1,400,881		1,400,881	1,026	1,401,907		16
	C. General Administration										
17	Administrative	107,640			107,640		107,640	149,335	256,975		17
18	Directors Fees										18
19	Professional Services			2,100	2,100		2,100	9,828	11,928		19
20	Dues, Fees, Subscriptions & Promotions			12,853	12,853		12,853	9,201	22,054		20
21	Clerical & General Office Expenses	36,614	6,094	7,419	50,127		50,127	4,051	54,178		21
22	Employee Benefits & Payroll Taxes			430,163	430,163	25,895	456,058	37,070	493,128		22
23	Inservice Training & Education							82	82		23
24	Travel and Seminar			1,817	1,817		1,817		1,817		24
25	Other Admin. Staff Transportation		2,352		2,352		2,352	3,564	5,916		25
26	Insurance-Prop.Liab.Malpractice			29,334	29,334		29,334	2,668	32,002		26
27	Other (specify):*										27
28	TOTAL General Administration	144,254	8,446	483,686	636,386	25,895	662,281	215,799	878,080		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,713,910	282,886	594,950	2,591,746		2,591,746	223,948	2,815,694		29

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

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

Facility Name & ID Number Heritage Fifty-Three

#0024836

Report Period Beginning:

7/1/05

Ending:

6/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			91,679	91,679	91,679	7,843	99,522				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						3,538	3,538				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			91,679	91,679	91,679	11,381	103,060				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			191,909	191,909	191,909		191,909				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			191,909	191,909	191,909		191,909				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,713,910	282,886	878,538	2,875,334	2,875,334	235,329	3,110,663				45

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

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning: 7/1/05

Ending: 6/30/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	235,329		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 235,329		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 235,329		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Heritage Fifty-Three

ID# 0024836
 Report Period Beginning: 7/1/05
 Ending: 6/30/06

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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
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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	0	308	0	0	0	0	0	0	0	0	0	308	2
3	Housekeeping	0	112	0	0	0	0	0	0	0	0	0	112	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,061	0	0	0	0	0	0	0	0	0	2,061	5
6	Maintenance	0	4,642	0	0	0	0	0	0	0	0	0	4,642	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	7,123	0	0	0	0	0	0	0	0	0	7,123	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	1,026	0	0	0	0	0	0	0	0	0	1,026	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	1,026	0	0	0	0	0	0	0	0	0	1,026	16
	C. General Administration													
17	Administrative	0	149,335	0	0	0	0	0	0	0	0	0	149,335	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,828	0	0	0	0	0	0	0	0	0	9,828	19
20	Fees, Subscriptions & Promotions	0	9,201	0	0	0	0	0	0	0	0	0	9,201	20
21	Clerical & General Office Expenses	0	4,051	0	0	0	0	0	0	0	0	0	4,051	21
22	Employee Benefits & Payroll Taxes	0	37,070	0	0	0	0	0	0	0	0	0	37,070	22
23	Inservice Training & Education	0	82	0	0	0	0	0	0	0	0	0	82	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	3,564	0	0	0	0	0	0	0	0	3,564	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,668	0	0	0	0	0	0	0	0	2,668	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	209,567	6,232	0	0	0	0	0	0	0	0	215,799	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	217,716	6,232	0	0	0	0	0	0	0	0	223,948	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	7,843	0	0	0	0	0	0	0	0	7,843	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	3,538	0	0	0	0	0	0	0	0	3,538	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	11,381	0	11,381	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	217,716	17,613	0	235,329	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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	\$	ARC/RIC	100.00%	\$ 308	\$ 308	1
2	V	3 Housekeeping		ARC/RIC	100.00%	112	112	2
3	V	5 Utilities		ARC/RIC	100.00%	2,061	2,061	3
4	V	6 Maintenance		ARC/RIC	100.00%	4,642	4,642	4
5	V	19 Account/Consult		ARC/RIC	100.00%	6,133	6,133	5
6	V	19 Legal Fees		ARC/RIC	100.00%	3,695	3,695	6
7	V	17 Administration Salaries		ARC/RIC	100.00%	149,335	149,335	7
8	V	20 Sub/Promotion/Printing		ARC/RIC	100.00%	9,201	9,201	8
9	V	21 Office Supplies		ARC/RIC	100.00%	3,212	3,212	9
10	V	21 Telephone		ARC/RIC	100.00%	839	839	10
11	V	22 Employee Benefits		ARC/RIC	100.00%	37,070	37,070	11
12	V	10 Medical/Hygiene Supplies		ARC/RIC	100.00%	1,026	1,026	12
13	V	23 Staff Training		ARC/RIC	100.00%	82	82	13
14	Total		\$			\$ 217,716	\$ * 217,716	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	ARC/RIC	100.00%			15
16	V	25	Other Administration, Staff Transportation	ARC/RIC	100.00%	3,564	3,564	16
17	V	26	Insurance/Prof/Liability	ARC/RIC	100.00%	2,668	2,668	17
18	V	32	Interest Mortgage	ARC/RIC	100.00%	3,538	3,538	18
19	V	30	Depreciation	ARC/RIC	100.00%	7,843	7,843	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		\$			\$ 17,613	\$ * 17,613	39

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

Facility Name & ID Number

Heritage Fifty-Three

#

0024836

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	None								\$	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:

7/1/05

Ending: 6/30/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Association for Retarded Citizens
 Street Address 4016 9th Street
 City / State / Zip Code Rock Island IL 61201
 Phone Number (309) 786-6474
 Fax Number (309) 786-9861

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

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	2	Food and Beverage	The percent of budgeted	1,084,466	17 programs	\$ 1,157	\$ 288,639	\$ 308	1
2	3	Housekeeping	Administrative costs are	1,084,466	17 programs	422	288,639	112	2
3	5	Utilities	to be allocated based on	1,084,466	17 programs	7,744	288,639	2,061	3
4	6	Maintenance	percentage of salary	1,084,466	17 programs	17,439	288,639	4,642	4
5	19	Accountant/Consultant		1,084,466	17 programs	23,042	288,639	6,133	5
6	19	Legal Fees		1,084,466	17 programs	13,882	288,639	3,695	6
7	17	Administrative Salaries		1,084,466	17 programs	561,077	288,639	149,335	7
8	20	Sub/Promotion/Printing		1,084,466	17 programs	34,571	288,639	9,201	8
9	21	Office Expense		1,084,466	17 programs	12,068	288,639	3,212	9
10	21	Telephone		1,084,466	17 programs	3,154	288,639	839	10
11	22	Employee Benefits		1,084,466	17 programs	139,277	288,639	37,070	11
12	10	Medical/Hygiene Supplies		1,084,466	17 programs	3,853	288,639	1,026	12
13	23	Staff Training		1,084,466	17 programs	309	288,639	82	13
14	24	Travel Seminar		1,084,466	17 programs	0	288,639	0	14
15	25	Other Administration, Staff Transportation		1,084,466	17 programs	13,389	288,639	3,564	15
16	26	Insurance/Prof/Liability		1,084,466	17 programs	10,025	288,639	2,668	16
17	32	Interest Mortgage		1,084,466	17 programs	13,291	288,639	3,538	17
18	30	Depreciation		1,084,466	17 programs	29,469	288,639	7,843	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 884,169	\$	\$ 235,329	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	None									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.)

Facility Name & ID Number Heritage Fifty-Three

0024836 Report Period Beginning: 7/1/05

Ending: 6/30/06

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2005 report.		\$ None	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).		\$ #VALUE!	3																				
4. Real Estate Tax accrual used for 2006 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.		\$ #VALUE!	7																				
<p>Real Estate Tax History:</p> <table border="1"> <tr> <td>Real Estate Tax Bill for Calendar Year:</td> <td>2001</td> <td>_____</td> <td>8</td> </tr> <tr> <td></td> <td>2002</td> <td>_____</td> <td>9</td> </tr> <tr> <td></td> <td>2003</td> <td>_____</td> <td>10</td> </tr> <tr> <td></td> <td>2004</td> <td>_____</td> <td>11</td> </tr> <tr> <td></td> <td>2005</td> <td>_____</td> <td>12</td> </tr> </table>				Real Estate Tax Bill for Calendar Year:	2001	_____	8		2002	_____	9		2003	_____	10		2004	_____	11		2005	_____	12
Real Estate Tax Bill for Calendar Year:	2001	_____	8																				
	2002	_____	9																				
	2003	_____	10																				
	2004	_____	11																				
	2005	_____	12																				
<table border="1"> <tr> <td colspan="4">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2005</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>				FOR BHF USE ONLY				13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13																				
14	PLUS APPEAL COST FROM LINE 5	\$	14																				
15	LESS REFUND FROM LINE 6	\$	15																				
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																				

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Fifty-Three COUNTY Rock Island

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 2005 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 2005.

(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? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

Facility Name & ID Number Heritage Fifty-Three

0024836 Report Period Beginning:

7/1/05 Ending:

6/30/06

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

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR 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	Garage		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		92,597	9
10	Remodel Restrooms/Asphalt driveway		1986		6,987		20			6,987	10
11	Remodel Kitchen		1988		4,339					4,339	11
12	Asphalt Parking Lot/Remodel Kitchen #2		1989		17,029					17,029	12
13	Air Conditioning Kitchen		1992		6,808	216	31.5	216		6,099	13
14	Roof Repair, Asphalt, Remodeling		1993		15,650	497	31.5	497		7,834	14
15	Plumbing Repairs, Sidewalk Ramp		1994		8,220	487	31.5	487		5,812	15
16	Roof and Hot Water System		1995		22,625	1,385	31.5	1,385		15,327	16
17	New Hot Water System		1996		50,449	1,149	31.5	1,149		12,064	17
18	Hot Water Continuation		1997		35,175	1,116	31.5	1,116		10,602	18
19	Hot Water Continuation		1997		4,202	210	31.5	210		1,890	19
20	Parking Lot Blacktop		1997		3,430	434	31.5	434		3,722	20
21	Shopper Driveway Fire Alarm Water Tank Tub		1998		35,520	1,032	31.5	1,032		7,740	21
22	Air/Fire Doors, Concrete Walks, Fuel Storage Tank		1999		35,720	1,134	31.5	1,134		5,108	22
23	8 Power Doors		2000		9,485	301	31.5	301		1,656	23
24	Automatic Doors		2000		9,989	317	31.5	317		1,744	24
25	Concrete Walks/5 areas		2000		2,550	81	31.5	81		445	25
26	Electrical for Auto Doors		2000		1,414	45	31.5	45		247	26
27	Electrical for Auto Doors		2000		1,365	43	31.5	43		237	27
28	Install Whirlpool Tub		2000		7,320	232	31.5	232		1,276	28
29	Bedroom Remodel/Salary Expense		2000		1,169	37	31.5	37		204	29
30	Twin Furnaces		2000		5,520	175	31.5	175		963	30
31	Blacktop Parking Lot		2001		3,960	126	31.5	126		566	31
32	Air Conditioning Repairs		2001		1,411	45	31.5	45		202	32
33	Install 8 Furnace Units		2001		10,400	330	31.5	330		1,485	33
34	Install 2 Air Conditioning Units		2001		4,250	135	31.5	135		607	34
35	Install Air Conditioning Units in Kitchen		2001		1,750	56	31.5	56		252	35
36	Electrical for Home Theatre		2001		530	17	31.5	17		76	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 Fifty-Three

0024836

Report Period Beginning:

7/1/05

Ending:

6/30/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Kick Plates/Door Guards	2001	\$ 900	\$ 29	31.5	\$ 29	\$	\$ 130	37
38	Concrete Sidewalk/Ramp	2002	3,525	112	31.5	112		392	38
39	Install 2 Air Conditioning Units	2002	2,125	67	31.5	67		235	39
40	Install 5 Fire Doors	2002	643	20	31.5	20		70	40
41	Motor for Air Conditioning Unit	2002	500	16	31.5	16		56	41
42	Re-tile Floors	2002	18,750	595	31.5	595		2,083	42
43	Install 4 Wood Fire Doors	2002	546	17	31.5	17		60	43
44	Install Accordion Door	2002	4,495	143	31.5	143		500	44
45	Install Kitchen Hood Exhaust Fan	2002	2,114	67	31.5	67		235	45
46	Install 8 Countertops	2002	1,140	36	31.5	36		126	46
47	Install Sensory Room/Electrical Work	2002	1,606	51	31.5	51		178	47
48	Install Grease Trap	2004	3,640	116	31.5	116		290	48
49	Repairs to Automatic Doors	2004	2,805	89	31.5	89		223	49
50	Sewer Repairs	2004	3,537	112	31.5	112		280	50
51	Re-tile Kitchen Floor	2004	2,158	69	31.5	69		172	51
52	Sensory Room Electrical Work	2004	1,425	45	31.5	45		181	52
53	Install Air Conditioning Unit	2005	2,035	64	31.5	64		96	53
54	Update Fire System in Kitchen	2005	2,345	74	31.5	74		111	54
55	Install 29 Windows	2005	9,831	312	31.5	312		468	55
56	Install Whirlpool Tub	2005	2,898	92	31.5	92		138	56
57	Concrete Sidewalks	2005	3,650	116	31.5	116		174	57
58	Kitchen Cabinets	2005	4,705	149	31.5	149		224	58
59	Install Bathroom Tiles	2005	4,155	132	31.5	132		198	59
60	Install Lights/Electrical Work	2005	10,120	321	31.5	321		482	60
61	Install Ceiling Tiles/Drywall	2005	21,746	690	31.5	690		1,035	61
62	Install Fence around 4 buildings	2006	9,630	153	31.5	153		153	62
63	Concrete Patios/RV	2006	5,450	87	31.5	87		87	63
64	Concrete Patios/ER	2006	6,100	97	31.5	97		97	64
65	Commercial Garbage Disposal/Main Kitchen	2006	1,571	25	31.5	25		25	65
66	Replace Mixing Valves	2006	2,773	44	31.5	44		44	66
67	Paint interior of building,walls,trim,ceiling,doors/Riverview(RV)	2006	11,875	188	31.5	188		188	67
68	Removal of old tile and install new tile floor whole bldg/RV	2006	11,500	183	31.5	183		183	68
69	Building Electrical work/rewire Riverview Building (RV)	2006	3,055	48	31.5	48		48	69
70	TOTAL (lines 4 thru 69)		\$ 573,207	\$ 18,603		\$ 18,603	\$	\$ 216,072	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:

7/1/05

Ending:

6/30/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 573,207	\$ 18,603		\$ 18,603	\$	\$ 216,072	1
2	Kitchen Plumbing work/RV bldg	2006	1,209	19	31.5	19		19	2
3	Install Window Blinds/RV bldg	2006	1,519	24	31.5	24		24	3
4	Install Kitchen Sinks/Dishwasher/RV bldg	2006	866	14	31.5	14		14	4
5	Install 8 Bathroom Mirrors/RV bldg	2006	963	15	31.5	15		15	5
6	Install Kitchen/Laundry Cabinets and Countertops/RV bldg	2006	3,650	58	31.5	58		58	6
7	Install Wall Corner Guards Protection/RV	2006	596	9	31.5	9		9	7
8	Install Kitchen Ceramic Tile/Backsplash/RV	2006	2,424	38	31.5	38		38	8
9	install42 interior fire code safety doors & 3 exterior fire doors	2006	24,569	391	31.5	391		391	9
10	Install Kitchen/laundryCabinets and Countertops/Eagleridge	2006	4,705	75	31.5	75		75	10
11	Install Appliances/Eagleridge bldg (ER)	2006	530	8	31.5	8		8	11
12	Install Kitchen Ceramic Tile/Backsplash/Eagleridge (ER)	2006	468	7	31.5	7		7	12
13	Install Window Blinds/Physical Therapy Room (PT)	2006	530	8	31.5	8		8	13
14	Install Wall Mounted Reinforced Pulley System/PT Room	2006	2,002	32	31.5	32		32	14
15	Remove old tile and retile Floor/PT Room	2006	3,642	59	31.5	59		59	15
16	Install Unbreakable wallmounted Mirror/Rack/PT Room	2006	1,805	29	31.5	29		29	16
17	Install wall Studs, Drywall and Paint/PT Room	2006	5,304	85	31.5	85		85	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 627,989	\$ 19,474		\$ 19,474	\$	\$ 216,943	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: 7/1/05 Ending: 6/30/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 485,813	\$ 74,576	\$ 74,576	\$	10	\$ 422,755	71
72	Current Year Purchases	17,719	1,772	1,772		10	1,772	72
73	Fully Depreciated Assets	266,980						73
74								74
75	TOTALS	\$ 770,512	\$ 76,348	\$ 76,348	\$		\$ 424,527	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2004 Dode Grand Caravan	2004	\$ 18,502	\$ 3,700	\$ 3,700	\$	5	\$ 7,400	76
77										77
78										78
79										79
80	TOTALS			\$ 18,502	\$ 3,700	\$ 3,700	\$		\$ 7,400	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	1,515,597	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	99,522	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	99,522	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	648,870	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.

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning: 7/1/05

Ending: 6/30/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

* 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? If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <u>60</u>	IN-HOUSE PROGRAM <u>80</u>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>80</u>
		HOURS PER CNA <u>60</u>	

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	125	150		275
3	Classroom Wages (a)	2,126	3,189		5,315
4	Clinical Wages (b)	2,835	4,253		7,088
5	In-House Trainer Wages (c)	10,349	23,715		34,064
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 15,435	\$ 31,307	\$	\$ 46,742
10	SUM OF line 9, col. 1 and 2 (e)	\$ 46,742			

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	<u>6</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>5</u>
2. From other facilities (f)	
TOTAL TRAINED	11

- (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.)

	Service	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					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	Exceptional Care Program									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.

Facility Name & ID Number Heritage Fifty-Three# 0024836Report Period Beginning: 7/1/05

Ending:

6/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/06

(last day of reporting year)

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	\$ 656,292	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	504,316		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,829		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,163,437	\$	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	627,989		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	789,014		16
17	Accumulated Depreciation (book methods)	(648,870)		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)	\$ 866,727	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,030,164	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 61,691	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	382,588		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			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)	\$ 444,279	\$	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)	\$ 444,279	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,585,885	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,030,164	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,457,599	1
2	Restatements (describe):		2
3	Reclassification of Fixed assets	55,001	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,512,600	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	73,285	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)	\$ 73,285	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)	\$ 1,585,885	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Fifty-Three# 0024836Report Period Beginning: 7/1/05Ending: 6/30/06**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	\$ 2,812,528	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,812,528	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	370	9
10	Other Government Grants	8,108	10
11	CNA Training Reimbursements	14,975	11
12	Gift and Coffee Shop	4,988	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,024	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	15,600	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 49,065	23
D. Non-Operating Revenue			
24	Contributions	59,014	24
25	Interest and Other Investment Income***	12,793	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 71,807	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Day Training Revenue	11,118	28
28a	Fundraising events	5,822	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,940	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,950,340	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	599,434	31
32	Health Care	1,389,210	32
33	General Administration	604,823	33
B. Capital Expense			
34	Ownership	91,679	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	191,909	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,877,055	40
41	Income before Income Taxes (line 30 minus line 40)**	73,285	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 73,285	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.

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/05

Ending:

6/30/06

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	983	1,057	\$ 20,773	\$ 19.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	394	424	8,323	19.63	3
4	Licensed Practical Nurses	12,081	12,991	198,800	15.30	4
5	CNAs & Orderlies					5
6	CNA Trainees	1,158	1,220	12,403	10.17	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	1,934	2,080	27,927	13.43	13
14	Head Cook	1,762	1,895	17,141	9.05	14
15	Cook Helpers/Assistants	13,261	14,260	116,735	8.19	15
16	Dishwashers					16
17	Maintenance Workers	1,955	2,080	21,564	10.37	17
18	Housekeepers	6,202	6,669	56,450	8.46	18
19	Laundry					19
20	Administrator	1,253	2,080	41,719	20.06	20
21	Assistant Administrator	1,986	2,383	33,256	13.96	21
22	Other Administrative	1,102	1,186	32,665	27.54	22
23	Office Manager	2,058	2,080	24,413	11.74	23
24	Clerical	989	1,064	12,201	11.47	24
25	Vocational Instruction					25
26	Academic Instruction	1,729	1,804	34,064	18.88	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,945	3,167	53,212	16.80	28
29	Resident Services Coordinator	9,634	10,400	138,796	13.35	29
30	Habilitation Aides (DD Homes)	76,993	80,679	863,468	10.70	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,419	147,519	\$ 1,713,910 *	\$ 11.62	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	89	\$ 3,579	L1c3	35
36	Medical Director	Annual	4,725	L9c3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Annual	479	L10c3	39
40	Physical Therapy Consultant	2	75	L10c3	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	Psychological Services	1	60	L10c3	47
48					48
49	TOTAL (lines 35 - 48)	92	\$ 8,918		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

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? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X 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. \$ _____
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. \$ 25,895 Has any meal income been offset against related costs? No Indicate the amount. \$ No
- (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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? _____
Attach invoices and a summary of services for all architect and appraisal fees.