

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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: 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 7/1/06 to 6/30/07 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.

(Signed) _____ (Date) _____

(Type or Print Name) Kyle Rick

(Title) Executive Director

(Signed) _____ (Date) _____

Paid Preparer

(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: 7/1/06 Ending: 6/30/07

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>16,827</u>			<u>16,827</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>16,827</u>			<u>16,827</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.04%

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

237 (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

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/07 Fiscal Year: 6/30/07

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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/06 Ending: 6/30/07

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	170,401	2,620	3,570	176,591		176,591		176,591		1
2	Food Purchase		136,293		136,293	(25,625)	110,668	213	110,881		2
3	Housekeeping	65,953	18,960	8,510	93,423		93,423	176	93,599		3
4	Laundry		4,685		4,685		4,685		4,685		4
5	Heat and Other Utilities			71,592	71,592		71,592	1,255	72,847		5
6	Maintenance	23,022	45,821	6,237	75,080		75,080	5,672	80,752		6
7	Other (specify):*										7
8	TOTAL General Services	259,376	208,379	89,909	557,664	(25,625)	532,039	7,316	539,355		8
	B. Health Care and Programs										
9	Medical Director			4,725	4,725		4,725		4,725		9
10	Nursing and Medical Records	1,181,043	44,739	829	1,226,611		1,226,611	2,961	1,229,572		10
10a	Therapy										10a
11	Activities		8,590		8,590		8,590		8,590		11
12	Social Services	68,668			68,668		68,668		68,668		12
13	CNA Training	53,740	500		54,240		54,240		54,240		13
14	Program Transportation		13,049		13,049		13,049		13,049		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,303,451	66,878	5,554	1,375,883		1,375,883	2,961	1,378,844		16
	C. General Administration										
17	Administrative	66,171			66,171		66,171	160,955	227,126		17
18	Directors Fees										18
19	Professional Services			2,100	2,100		2,100	10,376	12,476		19
20	Dues, Fees, Subscriptions & Promotions			6,139	6,139		6,139	15,830	21,969		20
21	Clerical & General Office Expenses	36,886	8,496	5,984	51,366		51,366	4,555	55,921		21
22	Employee Benefits & Payroll Taxes			399,524	399,524	25,625	425,149	44,122	469,271		22
23	Inservice Training & Education							230	230		23
24	Travel and Seminar			628	628		628	1,291	1,919		24
25	Other Admin. Staff Transportation		2,242		2,242		2,242	1,759	4,001		25
26	Insurance-Prop.Liab.Malpractice			21,833	21,833		21,833	3,743	25,576		26
27	Other (specify):*										27
28	TOTAL General Administration	103,057	10,738	436,208	550,003	25,625	575,628	242,861	818,489		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,665,884	285,995	531,671	2,483,550		2,483,550	253,138	2,736,688		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: 7/1/06 Ending: 6/30/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			93,689	93,689	93,689	8,505	102,194				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						857	857				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			93,689	93,689	93,689	9,362	103,051				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			168,752	168,752	168,752		168,752				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			168,752	168,752	168,752		168,752				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,665,884	285,995	794,112	2,745,991	2,745,991	262,500	3,008,491				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: 7/1/06

Ending: 6/30/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

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)	262,500		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 262,500		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 262,500		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.

		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: 7/1/06

Ending: 6/30/07

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:

7/1/06

Ending:

6/30/07

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	213	0	0	0	0	0	0	0	0	0	213	2
3	Housekeeping	0	176	0	0	0	0	0	0	0	0	0	176	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,255	0	0	0	0	0	0	0	0	0	1,255	5
6	Maintenance	0	5,672	0	0	0	0	0	0	0	0	0	5,672	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	7,316	0	0	0	0	0	0	0	0	0	7,316	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	2,961	0	0	0	0	0	0	0	0	0	2,961	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	2,961	0	0	0	0	0	0	0	0	0	2,961	16
	C. General Administration													
17	Administrative	0	160,955	0	0	0	0	0	0	0	0	0	160,955	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,376	0	0	0	0	0	0	0	0	0	10,376	19
20	Fees, Subscriptions & Promotions	0	15,830	0	0	0	0	0	0	0	0	0	15,830	20
21	Clerical & General Office Expenses	0	4,555	0	0	0	0	0	0	0	0	0	4,555	21
22	Employee Benefits & Payroll Taxes	0	44,122	0	0	0	0	0	0	0	0	0	44,122	22
23	Inservice Training & Education	0	230	0	0	0	0	0	0	0	0	0	230	23
24	Travel and Seminar	0	0	1,291	0	0	0	0	0	0	0	0	1,291	24
25	Other Admin. Staff Transportation	0	0	1,759	0	0	0	0	0	0	0	0	1,759	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,743	0	0	0	0	0	0	0	0	3,743	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	236,068	6,793	0	0	0	0	0	0	0	0	242,861	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	246,345	6,793	0	0	0	0	0	0	0	0	253,138	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/06

Ending:

6/30/07

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	8,505	0	0	0	0	0	0	0	0	8,505	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	857	0	0	0	0	0	0	0	0	857	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	9,362	0	9,362	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	246,345	16,155	0	262,500	45							

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/06

Ending:

6/30/07

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%	\$ 213	\$ 213 1
2	V	3 Housekeeping		ARC/RIC	100.00%	176	176 2
3	V	5 Utilities		ARC/RIC	100.00%	1,255	1,255 3
4	V	6 Maintenance		ARC/RIC	100.00%	5,672	5,672 4
5	V	19 Account/Consult		ARC/RIC	100.00%	8,412	8,412 5
6	V	19 Legal Fees		ARC/RIC	100.00%	1,964	1,964 6
7	V	17 Administration Salaries		ARC/RIC	100.00%	160,955	160,955 7
8	V	20 Sub/Promotion/Printing		ARC/RIC	100.00%	15,830	15,830 8
9	V	21 Office Supplies		ARC/RIC	100.00%	3,643	3,643 9
10	V	21 Telephone		ARC/RIC	100.00%	912	912 10
11	V	22 Employee Benefits		ARC/RIC	100.00%	44,122	44,122 11
12	V	10 Medical/Hygiene Supplies		ARC/RIC	100.00%	2,961	2,961 12
13	V	23 Staff Training		ARC/RIC	100.00%	230	230 13
14	Total		\$			\$ 246,345	\$ * 246,345 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%	\$ 1,291	\$ 1,291	15
16	V	25	Other Administration, Staff Transportation		ARC/RIC	100.00%	1,759	1,759	16
17	V	26	Insurance/Prof/Liability		ARC/RIC	100.00%	3,743	3,743	17
18	V	32	Interest Mortgage		ARC/RIC	100.00%	857	857	18
19	V	30	Depreciation		ARC/RIC	100.00%	8,505	8,505	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		\$				\$ 16,155	\$ * 16,155	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:

7/1/06

Ending:

6/30/07

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:

7/1/06

Ending: 6/30/07

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	\$ 761	\$ 302,907	\$ 213	1
2	3	Housekeeping	Administrative costs are	1,084,466	17 programs	631	302,907	176	2
3	5	Utilities	to be allocated based on	1,084,466	17 programs	4,492	302,907	1,255	3
4	6	Maintenance	percentage of salary	1,084,466	17 programs	20,308	302,907	5,672	4
5	19	Accountant/Consultant		1,084,466	17 programs	30,116	302,907	8,412	5
6	19	Legal Fees		1,084,466	17 programs	7,031	302,907	1,964	6
7	17	Administrative Salaries		1,084,466	17 programs	576,251	576,251	160,955	7
8	20	Sub/Promotion/Printing		1,084,466	17 programs	56,673	302,907	15,830	8
9	21	Office Expense		1,084,466	17 programs	13,041	302,907	3,643	9
10	21	Telephone		1,084,466	17 programs	3,265	302,907	912	10
11	22	Employee Benefits		1,084,466	17 programs	157,967	302,907	44,122	11
12	10	Medical/Hygiene Supplies		1,084,466	17 programs	10,601	302,907	2,961	12
13	23	Staff Training		1,084,466	17 programs	824	302,907	230	13
14	24	Travel Seminar		1,084,466	17 programs	4,621	302,907	1,291	14
15	25	Other Administration, Staff Transportation		1,084,466	17 programs	6,296	302,907	1,759	15
16	26	Insurance/Prof/Liability		1,084,466	17 programs	13,400	302,907	3,743	16
17	32	Interest Mortgage		1,084,466	17 programs	3,069	302,907	857	17
18	30	Depreciation		1,084,466	17 programs	30,448	302,907	8,505	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 939,795	\$ 576,251	\$ 262,500	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

7/1/06 Ending:

6/30/07

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:

7/1/06

Ending:

6/30/07

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		6,315	13
14	Roof Repair, Asphalt, Remodeling		1993		15,650	497	31.5	497		8,331	14
15	Plumbing Repairs, Sidewalk Ramp		1994		8,220	487	31.5	487		6,299	15
16	Roof and Hot Water System		1995		22,625	1,385	31.5	1,385		16,712	16
17	New Hot Water System		1996		50,449	1,149	31.5	1,149		13,213	17
18	Hot Water Continuation		1997		35,175	1,116	31.5	1,116		11,718	18
19	Hot Water Continuation		1997		4,202	210	31.5	210		2,100	19
20	Parking Lot Blacktop		1997		3,430	434	31.5	434		4,156	20
21	Shopper Driveway Fire Alarm Water Tank Tub		1998		35,520	1,032	31.5	1,032		8,772	21
22	Air/Fire Doors, Concrete Walks, Fuel Storage Tank		1999		35,720	1,134	31.5	1,134		6,242	22
23	8 Power Doors		2000		9,485	301	31.5	301		1,957	23
24	Automatic Doors		2000		9,989	317	31.5	317		2,061	24
25	Concrete Walks/5 Areas		2000		2,550	81	31.5	81		526	25
26	Electrical for Auto Doors		2000		1,414	45	31.5	45		292	26
27	Electrical for Auto Doors		2000		1,365	43	31.5	43		280	27
28	Install Whirlpool Tub		2000		7,320	232	31.5	232		1,508	28
29	Bedroom Remodel/Salary Expense		2000		1,169	37	31.5	37		241	29
30	Twin Furnaces		2000		5,520	175	31.5	175		1,138	30
31	Blacktop Parking Lot		2001		3,960	126	31.5	126		692	31
32	Air Conditioning Repairs		2001		1,411	45	31.5	45		247	32
33	Install 8 Furnace Units		2001		10,400	330	31.5	330		1,815	33
34	Install 2 Air Conditioning Units		2001		4,250	135	31.5	135		742	34
35	Install Air Conditioning Units in Kitchen		2001		1,750	56	31.5	56		308	35
36	Electrical for Home Theatre		2001		530	17	31.5	17		93	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:

7/1/06

Ending:

6/30/07

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	\$	\$ 159	37
38	Concrete Sidewalk/Ramp	2002	3,525	112	31.5	112		504	38
39	Install 2 Air Conditioning Units	2002	2,125	67	31.5	67		302	39
40	Install 5 Fire Doors	2002	643	20	31.5	20		90	40
41	Motor for Air Conditioning Unit	2002	500	16	31.5	16		72	41
42	Re-tile Floors	2002	18,750	595	31.5	595		2,678	42
43	Install 4 Wood Fire Doors	2002	546	17	31.5	17		77	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		302	45
46	Install 8 Countertops	2002	1,140	36	31.5	36		162	46
47	Install Sensory Room/Electrical Work	2002	1,606	51	31.5	51		229	47
48	Install Grease Trap	2004	3,640	116	31.5	116		406	48
49	Repairs to Automatic Doors	2004	2,805	89	31.5	89		312	49
50	Sewer Repairs	2004	3,537	112	31.5	112		392	50
51	Re-Tile Kitchen Floor	2004	2,158	69	31.5	69		241	51
52	Sensory Room Electrical Work	2004	1,425	45	31.5	45		226	52
53	Install Air conditioning Unit	2005	2,035	64	31.5	64		160	53
54	Update Fire System in Kitchen	2005	2,345	74	31.5	74		185	54
55	Install 29 Windows	2005	9,831	312	31.5	312		780	55
56	Install Whirlpool Tub	2005	2,898	92	31.5	92		230	56
57	Concrete Sidewalks	2005	3,650	116	31.5	116		290	57
58	Kitchen Cabinets	2005	4,705	149	31.5	149		373	58
59	Install Bathroom Tiles	2005	4,155	132	31.5	132		330	59
60	Install Lights/Electrical Work	2005	10,120	321	31.5	321		803	60
61	Install Ceiling Tiles/Drywall	2005	21,746	690	31.5	690		1,725	61
62	Building Renovations/RV	2006	62,226	1,975	31.5	1,975		2,963	62
63	Building Renovations/BV	2006	5,703	181	31.5	181		272	63
64	Install Fence around 4 buildings	2006	9,630	306	31.5	306		459	64
65	Concrete Patios/RV	2006	5,450	173	31.5	173		260	65
66	Concrete Patios/ER	2006	6,100	194	31.5	194		291	66
67	Commercial Garbage Disposal/Main Kitchen	2006	1,571	50	31.5	50		75	67
68	Replace Mixing Valves	2006	2,773	88	31.5	88		132	68
69	Remodel PT Room	2006	13,283	422	31.5	422		633	69
70	TOTAL (lines 4 thru 69)		\$ 627,989	\$ 21,167		\$ 21,167	\$	\$ 233,323	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:

7/1/06

Ending:

6/30/07

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		\$ 627,989	\$ 21,167		\$ 21,167	\$	\$ 233,323	1
2	Generator Repairs	2007	1,244	20	31.5	20		20	2
3	Install New Bedroom and Bathroom Doors	2007	6,611	105	31.5	105		105	3
4	Retile Main Building Office/Hallways	2007	4,175	66	31.5	66		66	4
5	Sidewalk Repair between LW/RV	2007	1,200	19	31.5	19		19	5
6	New Fence around all buildings	2007	13,267	211	31.5	211		211	6
7	Install Fire Wall	2007	850	13	31.5	13		13	7
8	Build/Repair Walls	2007	1,400	22	31.5	22		22	8
9	Repair 3 doors BV	2007	680	11	31.5	11		11	9
10	Install Air Conditioning Unit in Kitchen	2007	2,900	46	31.5	46		46	10
11	Install 22 Windows LW	2007	8,360	133	31.5	133		133	11
12	Replace door and lock RV	2007	990	16	31.5	16		16	12
13	Clean Mixing Valves	2007	6,519	103	31.5	103		103	13
14	Install Kitchen Cabinets LW	2007	1,269	20	31.5	20		20	14
15	Repair Hot Water Heater RV	2007	1,578	25	31.5	25		25	15
16	Install 3 Soft Lite Windoww	2007	1,259	20	31.5	20		20	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 680,291	\$ 21,997		\$ 21,997	\$	\$ 234,153	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: 7/1/06 Ending: 6/30/07

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 503,532	\$ 75,118	\$ 75,118	\$		\$ 428,071	71
72	Current Year Purchases	13,792	1,379	1,379			1,379	72
73	Fully Depreciated Assets	266,980						73
74								74
75	TOTALS	\$ 784,304	\$ 76,497	\$ 76,497	\$		\$ 429,450	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 Dodge Grand Caravan	2004	\$ 18,502	\$ 3,700	\$ 3,700	\$		\$ 11,100	76
77										77
78										78
79										79
80	TOTALS			\$ 18,502	\$ 3,700	\$ 3,700	\$		\$ 11,100	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)	\$ 1,581,691	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,194	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 102,194	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)	\$ 674,703	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: 7/1/06

Ending: 6/30/07

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

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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

* 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.

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/06 Ending: 6/30/07

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="text" value="60"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>COMMUNITY COLLEGE <input type="text"/></p> <p>HOURS PER CNA <u>60</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="text" value="80"/></p> <p>IN OTHER FACILITY <input type="text"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	200	300		500
3	Classroom Wages (a)	3,400	6,384		9,784
4	Clinical Wages (b)	4,536	8,508		13,044
5	In-House Trainer Wages (c)	10,752	20,160		30,912
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 18,888	\$ 35,352	\$	\$ 54,240
10	SUM OF line 9, col. 1 and 2 (e)	\$ 54,240			

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	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	
TOTAL TRAINED	20

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heritage Fifty-Three# 0024836

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	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 prescripts							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: 7/1/06

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/07

(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	\$ 752,477	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	509,578		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,712		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,264,767	\$	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	680,291		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	802,806		16
17	Accumulated Depreciation (book methods)	(674,703)		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)	\$ 906,988	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,171,755	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 54,694	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	378,870		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)	\$ 433,564	\$	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)	\$ 433,564	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,738,191	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,171,755	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,585,885	1
2	Restatements (describe):		2
3	Reclassification of Fixed assets	(87,214)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,498,671	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	239,520	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)	\$ 239,520	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)	\$ 1,738,191	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Fifty-Three# 0024836Report Period Beginning: 7/1/06Ending: 6/30/07**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	\$ 2,848,369	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,848,369	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	378	9
10	Other Government Grants	8,875	10
11	CNA Training Reimbursements	14,963	11
12	Gift and Coffee Shop	3,836	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	2,891	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	10,400	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 41,343	23
D. Non-Operating Revenue			
24	Contributions	29,684	24
25	Interest and Other Investment Income***	20,727	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 50,411	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Day Training Revenue</u>	29,275	28
28a	<u>Fundraising events</u>	16,113	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 45,388	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,985,511	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	557,664	31
32	Health Care	1,375,883	32
33	General Administration	550,003	33
B. Capital Expense			
34	Ownership	93,689	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	168,752	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,745,991	40
41	Income before Income Taxes (line 30 minus line 40)**	239,520	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 239,520	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.

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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	1,905	2,048	\$ 39,015	\$ 19.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	13,000	13,978	201,907	14.44	4
5	CNAs & Orderlies					5
6	CNA Trainees	2,281	2,281	22,828	10.01	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	28,077	13.50	13
14	Head Cook	2,011	2,162	23,432	10.84	14
15	Cook Helpers/Assistants	13,114	14,102	118,892	8.43	15
16	Dishwashers					16
17	Maintenance Workers	2,556	2,748	23,022	8.38	17
18	Housekeepers	8,151	8,765	65,953	7.52	18
19	Laundry					19
20	Administrator	1,953	2,080	41,751	20.07	20
21	Assistant Administrator					21
22	Other Administrative	833	896	24,420	27.25	22
23	Office Manager	1,569	1,687	22,166	13.14	23
24	Clerical	1,539	1,655	14,720	8.89	24
25	Vocational Instruction					25
26	Academic Instruction	2,100	2,258	30,912	13.69	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,875	4,160	68,668	16.51	28
29	Resident Services Coordinator	11,651	10,270	140,563	13.69	29
30	Habilitation Aides (DD Homes)	73,570	79,108	799,558	10.11	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,042	150,278	\$ 1,665,884 *	\$ 11.09	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	\$ 3,570	L1c3	35
36	Medical Director				36
37	Medical Records Consultant	Annual	4,725	L9c3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		304	L10C3	39
40	Physical Therapy Consultant		175	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	Dental Consultant		350	L10C3	47
48					48
49	TOTAL (lines 35 - 48)	89	\$ 9,124		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Susan Smith	Administrator		\$ 41,751	Workers' Compensation Insurance	\$ 36,207	IDPH License Fee	\$ 2,200	
Julie Williams	Assoc. Ex. Dir.		24,420	Unemployment Compensation Insurance	1,939	Advertising: Employee Recruitment	8,609	
				FICA Taxes	135,732	Health Care Worker Background Check (Indicate # of checks performed <u>40</u>)	600	
				Employee Health Insurance	98,041	Patient Background Checks		
				Employee Meals	25,625	Arc of IL Dues and US Dues	3,226	
				Illinois Municipal Retirement Fund (IMRF)*		Staff Awards and Promotions,advocacy	6,134	
				Pension Expense Employer Paid	121,193	Subscriptions	425	
				Disability Insurance	2,962	Direct Deposit Fees	775	
				Group Term Insurance	2,827			
				Admin Fringe Benefits from schedule VIII line 11 c9	44,122	Less: Public Relations Expense	()	
				Immunization Costs	622	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 66,171	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 21,969
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
\$				\$			\$	
							Out-of-State Travel	
							In-State Travel	
							1,919	
							Seminar Expense	
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$				\$			\$ 1,919	
2,100								

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Fifty-Three

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. \$ 168,752
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. \$ 25,625 Has any meal income been offset against related costs? No Indicate the amount. \$ None
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ None
c. What percent of all travel expense relates to transportation of nurses and patients? No
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ None
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey and Pullen, LLP 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 \$5,000, 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.