



Facility Name & ID Number Heritage Fifty-Three# 0024836 Report Period Beginning: 7/1/07 Ending: 6/30/08

## 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>17,355</u>			<u>17,355</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>17,355</u>			<u>17,355</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.06%

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

165 (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)

NoneF. Does the facility maintain a daily midnight census? yes

G. Do pages 3 &amp; 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: 6/30/08 Fiscal Year: 6/30/08

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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/07 Ending: 6/30/08

**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
	<b>A. General Services</b>										
1	Dietary	140,663	2,829	3,596	147,088		147,088		147,088		1
2	Food Purchase		154,649		154,649	(25,680)	128,969	196	129,165		2
3	Housekeeping	48,804	27,293	9,872	85,969		85,969	4,014	89,983		3
4	Laundry		6,890		6,890		6,890		6,890		4
5	Heat and Other Utilities			86,665	86,665		86,665	955	87,620		5
6	Maintenance	9,700	57,216	9,493	76,409		76,409	3,292	79,701		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	199,167	248,877	109,626	557,670	(25,680)	531,990	8,457	540,447		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,775	4,775		4,775		4,775		9
10	Nursing and Medical Records	1,271,895	39,450	555	1,311,900		1,311,900	412	1,312,312		10
10a	Therapy										10a
11	Activities		6,083		6,083		6,083		6,083		11
12	Social Services	65,198			65,198		65,198		65,198		12
13	CNA Training	44,384	475		44,859		44,859		44,859		13
14	Program Transportation		19,098		19,098		19,098		19,098		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,381,477	65,106	5,330	1,451,913		1,451,913	412	1,452,325		16
	<b>C. General Administration</b>										
17	Administrative	75,661			75,661		75,661	151,034	226,695		17
18	Directors Fees										18
19	Professional Services							7,244	7,244		19
20	Dues, Fees, Subscriptions & Promotions			19,499	19,499		19,499	9,435	28,934		20
21	Clerical & General Office Expenses	35,127	7,269	10,371	52,767		52,767	3,692	56,459		21
22	Employee Benefits & Payroll Taxes			366,251	366,251	25,680	391,931	41,787	433,718		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,150	1,150		1,150	589	1,739		24
25	Other Admin. Staff Transportation		1,947		1,947		1,947	5,812	7,759		25
26	Insurance-Prop.Liab.Malpractice			21,681	21,681		21,681	8,877	30,558		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	110,788	9,216	418,952	538,956	25,680	564,636	228,470	793,106		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,691,432	323,199	533,908	2,548,539		2,548,539	237,339	2,785,878		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:

7/1/07

Ending:

6/30/08

## 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	
	<b>D. Ownership</b>											
30	Depreciation			89,167	89,167	89,167	7,566	96,733				30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			89,167	89,167	89,167	7,566	96,733				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,482	160,482	160,482		160,482				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			160,482	160,482	160,482		160,482				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,691,432	323,199	783,557	2,798,188	2,798,188	244,905	3,043,093				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: 7/1/07

Ending: 6/30/08

**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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$		\$	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)	244,905		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 244,905		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 244,905		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					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

Heritage Fifty-Three

ID# 0024836  
Report Period Beginning: 7/1/07  
Ending: 6/30/08

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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Fifty-Three

# 0024836

Report Period Beginning:

7/1/07

Ending:

6/30/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	196	0	0	0	0	0	0	0	0	0	196	2
3	Housekeeping	0	4,014	0	0	0	0	0	0	0	0	0	4,014	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	955	0	0	0	0	0	0	0	0	0	955	5
6	Maintenance	0	3,292	0	0	0	0	0	0	0	0	0	3,292	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	8,457	0	0	0	0	0	0	0	0	0	8,457	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	412	0	0	0	0	0	0	0	0	0	412	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	<b>TOTAL Health Care and Programs</b>	0	412	0	0	0	0	0	0	0	0	0	412	16
	<b>C. General Administration</b>													
17	Administrative	0	151,034	0	0	0	0	0	0	0	0	0	151,034	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,244	0	0	0	0	0	0	0	0	0	7,244	19
20	Fees, Subscriptions & Promotions	0	9,435	0	0	0	0	0	0	0	0	0	9,435	20
21	Clerical & General Office Expenses	0	3,692	0	0	0	0	0	0	0	0	0	3,692	21
22	Employee Benefits & Payroll Taxes	0	41,787	0	0	0	0	0	0	0	0	0	41,787	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	589	0	0	0	0	0	0	0	0	589	24
25	Other Admin. Staff Transportation	0	0	5,812	0	0	0	0	0	0	0	0	5,812	25
26	Insurance-Prop.Liab.Malpractice	0	0	8,877	0	0	0	0	0	0	0	0	8,877	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	213,192	15,278	0	0	0	0	0	0	0	0	228,470	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	0	222,061	15,278	0	0	0	0	0	0	0	0	237,339	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Fifty-Three

# 0024836

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	7,566	0	0	0	0	0	0	0	0	7,566	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>7,566</b>	<b>0</b>	<b>7,566</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>0</b>	<b>222,061</b>	<b>22,844</b>	<b>0</b>	<b>244,905</b>	<b>45</b>							

Facility Name & ID Number Heritage Fifty-Three

# 0024836

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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%	\$ 196	\$ 196
2	V	3 Housekeeping		ARC/RIC	100.00%	4,014	4,014
3	V	5 Utilities		ARC/RIC	100.00%	955	955
4	V	6 Maintenance		ARC/RIC	100.00%	3,292	3,292
5	V	19 Account/Consult		ARC/RIC	100.00%	6,077	6,077
6	V	19 Legal Fees		ARC/RIC	100.00%	1,167	1,167
7	V	17 Administration Salaries		ARC/RIC	100.00%	151,034	151,034
8	V	20 Sub/Promotion/Printing		ARC/RIC	100.00%	9,435	9,435
9	V	21 Office Supplies		ARC/RIC	100.00%	2,664	2,664
10	V	21 Telephone		ARC/RIC	100.00%	1,028	1,028
11	V	22 Employee Benefits		ARC/RIC	100.00%	41,787	41,787
12	V	10 Medical/Hygiene Supplies		ARC/RIC	100.00%	412	412
13	V	23 Staff Training		ARC/RIC	100.00%		
14	Total		\$			\$ 222,061	\$ * 222,061

\* 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%	\$ 589	\$ 589	15	
16	V	25	Other Administration, Staff Transportation	ARC/RIC	100.00%	5,812	5,812	16	
17	V	26	Insurance/Prof/Liability	ARC/RIC	100.00%	8,877	8,877	17	
18	V	32	Interest Mortgage	ARC/RIC	100.00%			18	
19	V	30	Depreciation	ARC/RIC	100.00%	7,566	7,566	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		\$			\$ 22,844	\$ *	22,844	39

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

Facility Name &amp; ID Number

Heritage Fifty-Three

#

0024836

Report Period Beginning:

7/1/07

Ending:

6/30/08

## 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:

7/1/07

Ending: 6/30/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

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	1,170,036	17 programs	\$ 743	\$ 308,962	\$ 196	1
2	3	Housekeeping	Administrative costs are	1,170,036	17 programs	15,201	308,962	4,014	2
3	5	Utilities	to be allocated based on	1,170,036	17 programs	3,618	308,962	955	3
4	6	Maintenance	percentage of salary	1,170,036	17 programs	12,466	308,962	3,292	4
5	19	Accountant/Consultant		1,170,036	17 programs	23,015	308,962	6,077	5
6	19	Legal Fees		1,170,036	17 programs	4,419	308,962	1,167	6
7	17	Administrative Salaries		1,170,036	17 programs	571,963	308,962	151,034	7
8	20	Sub/Promotion/Printing		1,170,036	17 programs	35,729	308,962	9,435	8
9	21	Office Expense		1,170,036	17 programs	10,089	308,962	2,664	9
10	21	Telephone		1,170,036	17 programs	3,892	308,962	1,028	10
11	22	Employee Benefits		1,170,036	17 programs	158,248	308,962	41,787	11
12	10	Medical/Hygiene Supplies		1,170,036	17 programs	1,560	308,962	412	12
13	23	Staff Training		1,170,036	17 programs	1	308,962	0	13
14	24	Travel Seminar		1,170,036	17 programs	2,229	308,962	589	14
15	25	Other Administration, Staff Transportation		1,170,036	17 programs	22,011	308,962	5,812	15
16	26	Insurance/Prof/Liability		1,170,036	17 programs	33,616	308,962	8,877	16
17	32	Interest Mortgage		1,170,036	17 programs	0	308,962	0	17
18	30	Depreciation		1,170,036	17 programs	28,654	308,962	7,566	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 927,454	\$	\$ 244,905	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	None									1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6										6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$	\$		\$	9										
<b>B. Non-Facility Related*</b>																				
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$	14										
15	<b>TOTALS (line 9+line14)</b>					\$	\$		\$	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: 7/1/07

Ending: 6/30/08

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

B. Real Estate Taxes

<p><b>Important</b>, 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 2007 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 2008 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																																		
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																																		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ #VALUE!	7																																		
Real Estate Tax History:																																					
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>_____</td><td>8</td></tr> <tr><td>2004</td><td>_____</td><td>9</td></tr> <tr><td>2005</td><td>_____</td><td>10</td></tr> <tr><td>2006</td><td>_____</td><td>11</td></tr> <tr><td>2007</td><td>_____</td><td>12</td></tr> </table>	2003	_____	8	2004	_____	9	2005	_____	10	2006	_____	11	2007	_____	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007</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>		<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2007	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2003	_____	8																																			
2004	_____	9																																			
2005	_____	10																																			
2006	_____	11																																			
2007	_____	12																																			
<b>FOR BHF USE ONLY</b>																																					
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

7/1/07 Ending:

6/30/08

**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	<b>TOTALS</b>	<b>196,020</b>		<b>\$ 98,594</b>	<b>3</b>

Facility Name &amp; ID Number Heritage Fifty-Three

# 0024836

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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
	<b>Improvement Type**</b>										
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		6,531	13
14	Roof Repair, Asphalt, Remodeling		1993		15,650	497	31.5	497		8,828	14
15	Plumbing Repairs, Sidewalk Ramp		1994		8,220	487	31.5	487		6,716	15
16	Roof and Hot Water System		1995		22,625	1,385	31.5	1,385		18,097	16
17	New Hot Water System		1996		50,449	1,149	31.5	1,149		14,362	17
18	Hot Water Continuation		1997		35,175	1,116	31.5	1,116		12,834	18
19	Hot Water Continuation		1997		4,202	210	31.5	210		2,310	19
20	Parking Lot Blacktop		1997		3,430	434	31.5	434		4,590	20
21	Shopper Driveway, Fire Alarm, Water Tank Tub		1998		35,520	1,032	31.5	1,032		9,804	21
22	Air/Fire Doors, Concrete Walks, Fuel Storage Tank		1999		35,720	1,134	31.5	1,134		7,376	22
23	8 Power Doors		2000		9,485	301	31.5	301		2,258	23
24	Automatic Doors		2000		9,989	317	31.5	317		2,378	24
25	Concrete Walks/5 Areas		2000		2,550	81	31.5	81		607	25
26	Electrical for Auto Doors		2000		1,414	45	31.5	45		337	26
27	Electrical for Auto Doors		2000		1,365	43	31.5	43		323	27
28	Install Whirlpool Tub		2000		7,320	232	31.5	232		1,740	28
29	Bedroom Remodel/Salary Expense		2000		1,169	37	31.5	37		278	29
30	Twin Furnaces		2000		5,520	175	31.5	175		1,313	30
31	Blacktop Parking Lot		2001		3,960	126	31.5	126		818	31
32	Air Conditioning Repairs		2001		1,411	45	31.5	45		292	32
33	Install 8 Furnace Units		2001		10,400	330	31.5	330		2,145	33
34	Install 2 Air Conditioning Units		2001		4,250	135	31.5	135		877	34
35	Install Air Conditioning Units in Kitchen		2001		1,750	56	31.5	56		364	35
36	Electrical for Home Theatre		2001		530	17	31.5	17		110	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 &amp; ID Number Heritage Fifty-Three

# 0024836

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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	\$	\$ 188	37
38	Concrete Sidewalk/Ramp	2002	3,525	112	31.5	112		616	38
39	Install 2 Air Conditioning Units	2002	2,125	67	31.5	67		369	39
40	Install 5 Fire Doors	2002	643	20	31.5	20		110	40
41	Motor for Air Conditioning Unit	2002	500	16	31.5	16		88	41
42	Re-tile Floors	2002	18,750	595	31.5	595		3,273	42
43	Install 4 Wood Fire Doors	2002	546	17	31.5	17		94	43
44	Install Accordion Door	2002	4,495	143	31.5	143		643	44
45	Install Kitchen Hood Exhaust Fan	2002	2,114	67	31.5	67		369	45
46	Install 8 Countertops	2002	1,140	36	31.5	36		198	46
47	Install Sensory Room/Electrical Work	2002	1,606	51	31.5	51		280	47
48	Install Grease Trap	2004	3,640	116	31.5	116		522	48
49	Repairs to Automatic Doors	2004	2,805	89	31.5	89		401	49
50	Sewer Repairs	2004	3,537	112	31.5	112		504	50
51	Re-Tile Kitchen Floor	2004	2,158	69	31.5	69		310	51
52	Sensory Room Electrical Work	2004	1,425	45	31.5	45		271	52
53	Install Air Conditioning Unit	2005	2,035	64	31.5	64		224	53
54	Update Fire System in Kitchen	2005	2,345	74	31.5	74		259	54
55	Install 29 Windows	2005	9,831	312	31.5	312		1,092	55
56	Install Whirlpool Tub	2005	2,898	92	31.5	92		322	56
57	Concrete Sidewalks	2005	3,650	116	31.5	116		406	57
58	Kitchen Cabinets	2005	4,705	149	31.5	149		522	58
59	Install Bathroom Tiles	2005	4,155	132	31.5	132		462	59
60	Install Lights/Electrical Work	2005	10,120	321	31.5	321		1,124	60
61	Install Ceiling Tiles/Drywall	2005	21,746	690	31.5	690		2,415	61
62	Building Renovations/RV	2006	62,226	1,975	31.5	1,975		4,938	62
63	Building Renovations/BV	2006	5,703	181	31.5	181		453	63
64	Install Fence around 4 buildings	2006	9,630	306	31.5	306		765	64
65	Concrete Patios/RV	2006	5,450	173	31.5	173		433	65
66	Concrete Patios/ER	2006	6,100	194	31.5	194		485	66
67	Commercial Garbage Disposal/Main Kitchen	2006	1,571	50	31.5	50		125	67
68	Replace Mixing Valves	2006	2,773	88	31.5	88		220	68
69	Remodel PT Room	2006	13,283	422	31.5	422		1,055	69
70	TOTAL (lines 4 thru 69)		\$ 627,989	\$ 21,167		\$ 21,167	\$	\$ 249,776	70

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

Facility Name &amp; ID Number Heritage Fifty-Three

# 0024836

Report Period Beginning:

7/1/07

Ending:

6/30/08

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 627,989	\$ 21,167		\$ 21,167	\$	\$ 249,776	1
2	Generator Repairs	2007	1,244	39	31.5	39		59	2
3	Install New Bedroom and Bathroom Doors	2007	6,611	210	31.5	210		315	3
4	Retile Main building Office/Hallways	2007	4,175	133	31.5	133		199	4
5	Sidewalk Repair between LW/RV	2007	1,200	38	31.5	38		57	5
6	New Fence around all buildings	2007	13,267	421	31.5	421		632	6
7	Install Fire Wall	2007	850	27	31.5	27		40	7
8	Build/Repair Walls	2007	1,400	44	31.5	44		66	8
9	Repair 3 doors BV	2007	680	22	31.5	22		33	9
10	Install Air Conditioning Unit in Kitchen	2007	2,900	92	31.5	92		138	10
11	Install 22 Windows LW	2007	8,360	265	31.5	265		398	11
12	Replace door and lock RV	2007	990	31	31.5	31		47	12
13	Clean Mixing Valves	2007	6,519	207	31.5	207		310	13
14	Install Kitchen Cabinets LW	2007	1,269	40	31.5	40		60	14
15	Repair Hot Water Heater RV	2007	1,578	50	31.5	50		75	15
16	Install 3 Soft Lite Windows	2007	1,259	40	31.5	40		60	16
17	Blacktop Front Circle Drive	2008	2,700	43	31.5	43		43	17
18	Repair Ducts in Main office building	2008	1,056	17	31.5	17		17	18
19	Install 16KW Generator	2008	13,200	210	31.5	210		210	19
20	Electrical Work/Main office building	2008	931	15	31.5	15		15	20
21	Wall/Plaster Repair Riverview	2008	1,125	18	31.5	18		18	21
22	Plumbing Work/Laundry facilities Riverview	2008	1,596	25	31.5	25		25	22
23	Clean Vents/Ducts Birchview	2008	965	15	31.5	15		15	23
24	Plumbing Work/Laundry & Sink hookup Birchview	2008	1,023	16	31.5	16		16	24
25	RegROUT Showers Birchview	2008	1,000	16	31.5	16		16	25
26	Install 4 Windows Birchview	2008	1,440	23	31.5	23		23	26
27	Install Closet Doors Birchview	2008	1,912	30	31.5	30		30	27
28	Install 4 Double Dressers Birchview	2008	3,680	58	31.5	58		58	28
29	Install Light Fixtures Birchview	2008	2,450	39	31.5	39		39	29
30	New Roof Birchview	2008	17,460	277	31.5	277		277	30
31	Wall/Plaster Repair Lakewood Remodel	2008	2,440	39	31.5	39		39	31
32	Wall Protectors and Installation Lakewood Remodel	2008	6,398	102	31.5	102		102	32
33	Install Bathroom Countertops/Towel bar Lakewood Remodel	2008	1,590	25	31.5	25		25	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 741,257	\$ 23,794		\$ 23,794	\$	\$ 253,233	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:

7/1/07

Ending:

6/30/08

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 741,257	\$ 23,794		\$ 23,794	\$	\$ 253,233	1
2	Tile/Grout work Kitchen Lakewood Remodel	2008	846	13	31.5	13		13	2
3	RegROUT Showers Lakewood Remodel	2008	2,000	32	31.5	32		32	3
4	New Window Blinds Lakewood Remodel	2008	5,041	80	31.5	80		80	4
5	Painting Lakewood Remodel	2008	1,905	30	31.5	30		30	5
6	Install Built-In Bedroom Dressers Lakewood Remodel	2008	3,640	58	31.5	58		58	6
7	Install 17 Windows Lakewood Remodel	2008	6,120	97	31.5	97		97	7
8	Install 8 Bathroom Mirrors Lakewood Remodel	2008	982	16	31.5	16		16	8
9	New Tile Flooring Lakewood Remodel	2008	2,267	36	31.5	36		36	9
10	Install New Bathroom Sinks/Faucents/Drains Lakewood Remodel	2008	6,386	101	31.5	101		101	10
11	Install Kitchen Cabinets/Countertops Lakewood Remodel	2008	6,510	103	31.5	103		103	11
12	Install 16 Closet Doors Lakewood Remodel	2008	7,648	121	31.5	121		121	12
13	Laminate 5 Med Closet Doors Lakewood Remodel	2008	1,090	17	31.5	17		17	13
14	Relaminate doors Lakewood Remodel	2008	4,270	68	31.5	68		68	14
15	Install New Doors/Frames Lakewood Remodel	2008	5,050	80	31.5	80		80	15
16	Electrical Work/Install Light Fixtures Lakewood Remodel	2008	15,892	252	31.5	252		252	16
17	Hardware supplies Lakewood Remodel	2008	1,933	31	31.5	31		31	17
18	Clean Vents/Ducts Lakewood	2008	965	15	31.5	15		15	18
19	Sidewalk Repair Lakewood	2008	7,050	112	31.5	112		112	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 820,852	\$ 25,056		\$ 25,056	\$	\$ 254,495	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: 7/1/07 Ending: 6/30/08

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	\$ 517,324	\$ 67,028	\$ 67,028	\$		\$ 440,390	71
72	Current Year Purchases	20,522	2,102	2,102			2,102	72
73	Fully Depreciated Assets	272,552						73
74								74
75	TOTALS	\$ 810,398	\$ 69,130	\$ 69,130	\$		\$ 442,492	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	2006 Chevy Uplander	2006	\$ 12,737	\$ 2,547	\$ 2,547	\$	5	\$ 5,094	76
77										77
78										78
79										79
80	TOTALS			\$ 12,737	\$ 2,547	\$ 2,547	\$		\$ 5,094	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)	\$ 1,742,581	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 96,733	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,733	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)	\$ 702,081	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: 7/1/07

Ending: 6/30/08

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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	<b>TOTAL</b>		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	275		475
3	Classroom Wages (a)	3,400	4,675		8,075
4	Clinical Wages (b)	4,536	6,237		10,773
5	In-House Trainer Wages (c)	10,752	14,784		25,536
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 18,888	\$ 25,971	\$	\$ 44,859
10	SUM OF line 9, col. 1 and 2 (e)	\$ 44,859			

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	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>19</b>

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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: 7/1/07

Ending:

6/30/08

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/08

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 628,535	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	765,375		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,627		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,409,537	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	98,594		13
14	Buildings, at Historical Cost	820,852		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	823,135		16
17	Accumulated Depreciation (book methods)	(702,081)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,040,500	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,450,037	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 109,997	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	375,137		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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 485,134	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 485,134	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,964,903	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,450,037	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,738,191	1
2	Restatements (describe):		2
3	Reclassification of Fixed Assets	13,163	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,751,354	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	213,549	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)	\$ 213,549	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,964,903	24 *

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

Facility Name & ID Number Heritage Fifty-Three# 0024836Report Period Beginning: 7/1/07Ending: 6/30/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,890,695	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,890,695	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education	389	9
10	Other Government Grants	3,943	10
11	CNA Training Reimbursements	18,157	11
12	Gift and Coffee Shop	3,459	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,428	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	3,602	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 31,978	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	43,128	24
25	Interest and Other Investment Income***	16,661	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 59,789	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Day training Revenue</b>	29,275	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 29,275	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,011,737	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	557,670	31
32	Health Care	1,451,913	32
33	General Administration	538,956	33
<b>B. Capital Expense</b>			
34	Ownership	89,167	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	160,482	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,798,188	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	213,549	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 213,549	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:

7/1/07

Ending:

6/30/08

**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	1,955	2,080	\$ 41,679	\$ 20.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses		11,818	170,633	14.44	4
5	CNAs & Orderlies					5
6	CNA Trainees		1,305	18,848	14.44	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor		2,080	27,726	13.33	13
14	Head Cook					14
15	Cook Helpers/Assistants		13,045	112,937	8.66	15
16	Dishwashers					16
17	Maintenance Workers		1,057	9,700	9.18	17
18	Housekeepers		5,391	48,804	9.05	18
19	Laundry					19
20	Administrator		2,080	44,938	21.60	20
21	Assistant Administrator					21
22	Other Administrative		1,040	30,723	29.54	22
23	Office Manager		1,602	21,322	13.31	23
24	Clerical		1,584	13,805	8.72	24
25	Vocational Instruction					25
26	Academic Instruction		1,835	25,536	13.92	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)		3,772	65,198	17.28	28
29	Resident Services Coordinator		10,600	143,763	13.56	29
30	Habilitation Aides (DD Homes)		83,526	915,820	10.96	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	1,955	142,815	\$ 1,691,432 *	\$ 11.84	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	90	\$ 3,596	L1c3	35
36	Medical Director				36
37	Medical Records Consultant	Annual	4,775	L9c3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	10	435	L10c3	39
40	Physical Therapy Consultant	3	120	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					47
48					48
49	TOTAL (lines 35 - 48)	103	\$ 8,926		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? \_\_\_\_\_  
If YES, give effective date of lease. No
- (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. \$ 160,482  
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. \$ 25,680 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.