

		FOR BHF USE					

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**2010**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2010)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0038620</u></p> <p><b>Facility Name:</b> <u>Heritage Nursing Home</u></p> <p><b>Address:</b> <u>5888 North Ridge</u> <u>Chicago</u> <u>60660</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(773) 769-2626</u> <b>Fax #</b> <u>(773) 769-2650</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>11/1/1992</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input checked="" type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>(847) 675-3585</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2010</u> to <u>12/31/2010</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>DAN SHABAT</u>            (Title) <u>OWNER</u> </td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>            (Date) _____            (Print Name and Title) <u>BOB KAGDA</u>  <u>VICE PRESIDENT</u>            (Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u>  <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>            (Telephone) <u>(847) 675-3585</u> <b>Fax #</b> <u>(847) 675-5777</u> </td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <span style="float: right;"><b>Phone # (217) 782-1630</b></span></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>DAN SHABAT</u> (Title) <u>OWNER</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> <b>Fax #</b> <u>(847) 675-5777</u>
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>DAN SHABAT</u> (Title) <u>OWNER</u>							
Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u> (Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>(847) 675-3585</u> <b>Fax #</b> <u>(847) 675-5777</u>							

Facility Name & ID Number Heritage Nursing Home

# 0038620 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	44	Skilled (SNF)	44	16,060	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,720	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	6,646	592	693	7,931	8	
9	SNF/PED					9	
10	ICF	32,907	421		33,328	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	39,553	1,013	693	41,259	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.31%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 07/01/02

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 21 and days of care provided 693

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Heritage Nursing Home # 0038620 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

**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	209,845	13,375	5,280	228,500		228,500		228,500		1
2	Food Purchase		189,922		189,922	(24,273)	165,649	(720)	164,929		2
3	Housekeeping	134,529	23,746		158,275		158,275		158,275		3
4	Laundry	29,264	11,250	4,553	45,067		45,067		45,067		4
5	Heat and Other Utilities			109,518	109,518		109,518		109,518		5
6	Maintenance	38,023	6,797	32,995	77,815		77,815	3,650	81,465		6
7	Other (specify):*			7,534	7,534		7,534		7,534		7
8	<b>TOTAL General Services</b>	411,661	245,090	159,880	816,631	(24,273)	792,358	2,930	795,288		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	1,284,574	61,553	27,877	1,374,004		1,374,004		1,374,004		10
10a	Therapy	11,806			11,806		11,806		11,806		10a
11	Activities	84,128	4,018	3,600	91,746		91,746		91,746		11
12	Social Services	39,030		4,458	43,488		43,488		43,488		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,419,538	65,571	46,935	1,532,044		1,532,044		1,532,044		16
	<b>C. General Administration</b>										
17	Administrative	194,074		418,000	612,074		612,074	(320,500)	291,574		17
18	Directors Fees										18
19	Professional Services			78,244	78,244		78,244	7,853	86,097		19
20	Dues, Fees, Subscriptions & Promotions			31,923	31,923		31,923	(17,627)	14,296		20
21	Clerical & General Office Expenses	200,328	10,311	16,388	227,027		227,027	(77,629)	149,398		21
22	Employee Benefits & Payroll Taxes			359,131	359,131	24,273	383,404		383,404		22
23	Inservice Training & Education			1,534	1,534		1,534		1,534		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			1,602	1,602		1,602	(1,602)			25
26	Insurance-Prop.Liab.Malpractice			783	783		783	105,894	106,677		26
27	Other (specify):*							7,429	7,429		27
28	<b>TOTAL General Administration</b>	394,402	10,311	907,605	1,312,318	24,273	1,336,591	(296,182)	1,040,409		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,225,601	320,972	1,114,420	3,660,993		3,660,993	(293,252)	3,367,741		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	5,280
	REPAIRS & MAINTENANCE	0
		0
		5,280
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	4,553
		0
		4,553
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	42,814
	ELECTRICITY	46,735
	WATER	19,204
	CABLE TV - LOBBY	765
		0
		109,518
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	0
	PAINTING & DECORATING	1,282
	BUILDING REPAIRS	24,117
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	3,336
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,260
	FIRE SERVICE	0
		0
		0
		0
		0
		32,995
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	7,534
	SECURITY SERVICE	0
		0
		0
		7,534
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	11,000
		11,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	21,379
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B 46-2	850
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,568
	PHARMACY CONSULTANT XVIII B 39-2	4,080
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		27,877
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,600
		0
		3,600
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,458
		0
		4,458
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	418,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	9,198
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	69,046
		0
		78,244
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	11,414
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	0
	EMPLOYEE RECRUITMENT/WANT ADS XIX F	2,320
	CONTRIBUTIONS VI 20 XIX F	1,000
	DUES & SUBSCRIPTIONS XIX F	8,226
	LICENSES & PERMITS XIX F	2,350
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	465
	CONTRIBUTIONS - POLITICAL - COPE VI 20 XIX F	4,748
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,400
	PATIENT BACKGROUND CHECKS XIX F	
		31,923
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	393
	EQUIPMENT REPAIR & MAINTENANCE	1,097
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	3,186
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	11,712
	MESSENGER SERVICE	0
		0
		16,388

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	169,011
	UNEMPLOYMENT COMPENSATION XIX D	18,974
	WORKERS COMPENSATION INSURANC XIX D	36,333
	HOSPITALIZATION INSURANCE XIX D	113,594
	EMPLOYEE BENEFITS - OTHER XIX D	0
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	16,695
	CHICAGO HEAD TAX XIX D	4,524
		0
		359,131
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	1,534
		1,534
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF - SEE PAGE 5A	1,602
		1,602
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	783
	INSURANCE SETTLEMENTS-ASSURECARE	
		783
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,114,420

**Heritage Nursing Home  
SCHEDULES  
12/31/2010**

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

TOTAL FOOD PURCHASE	189,922
LESS SALES TAX	<u>(720)</u>
NET FOOD	189,202
TOTAL PATIENT CENSUS	41,259
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	123,777
ADD # EMPLOYEE MEALS/DAY	50
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	18,250
PATIENT MEALS	123,777
ADD EMPLOYEE MEALS	<u>18,250</u>
TOTAL MEALS/YEAR	142,027
NET FOOD	189,202
DIVIDE TOTAL MEALS/YEAR	<u>142,027</u>
COST PER MEAL	1.33
TIME EMPLOYEE MEALS	<u>18,250</u>
<b>EMPLOYEE MEAL RECLASSIFICATION</b>	<b>24,273</b>
	=====

**PROFESSIONAL FEES  
PAGE 21 XIX. C.**

MEDIFAX EDI	DATA PROCESSING	110
MDI TECHNOLOGY	DATA PROCESSING	3,990
IVANS	DATA PROCESSING	2206
LIFE CARE SOFTWARE SOLUTIONS	DATA PROCESSING	2892
KRUPNICK, BOKOR, KAGDA & BROOKS	ACCOUNTING	16,360
OSTROW REISEN BERK ABRAMS	ACCOUNTING	2,224
STEVEN BRUEGGEMAN	ACCOUNTING	29,742
FROST RUTTENBERG ROTHBLATT	ACCOUNTING	109
KEMPSTER, KELLER, LENZ-CALVO	IMMIGRATION LEGAL	1,500
SKIDELSKY & ASSOCIATES	REAL ESTATE TAX LEGAL	13,438
MUCH SHELIST	LEGAL	1,973
RICHARD PEELO	MEDICARE COST REPORT	3,000
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULTANT	<u>700</u>
	<b>PROFESSIONAL FEES</b>	<b>78,244</b>
		=====

Facility Name &amp; ID Number

Heritage Nursing Home

#0038620

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

## 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			51,365	51,365		51,365	50,407	101,772			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,935	1,935		1,935	183,448	185,383			32
33	Real Estate Taxes							63,318	63,318			33
34	Rent-Facility & Grounds			659,128	659,128		659,128	(659,128)				34
35	Rent-Equipment & Vehicles			427	427		427		427			35
36	Other (specify):*							15,018	15,018			36
37	<b>TOTAL Ownership</b>			712,855	712,855		712,855	(346,937)	365,918			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		61,456	160,533	221,989		221,989		221,989			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,080	70,080		70,080		70,080			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		61,456	230,613	292,069		292,069		292,069			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,225,601	382,428	2,057,888	4,665,917		4,665,917	(640,189)	4,025,728			45

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

**VI. ADJUSTMENT DETAIL**

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

		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	(7,709)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(720)	2		13
14	Non-Care Related Interest	(37)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(465)	20		17
18	Fines and Penalties	(3,186)	21		18
19	Entertainment	(11,414)	20		19
20	Contributions	(5,748)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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	(76,045)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (105,324)		\$	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)	(534,865)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (534,865)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (640,189)		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					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	52

Heritage Nursing HomeID# 0038620Report Period Beginning: 01/01/2010Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (74,443)	21	1
2	MARKETING TRAVEL	(1,602)	25	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>	(76,045)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Nursing Home# 0038620

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

## 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	(720)	0	0	0	0	0	0	0	0	0	0	(720)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	3,650	0	0	0	0	0	0	0	0	0	3,650	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(720)</b>	<b>3,650</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>2,930</b>	<b>8</b>
	<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	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</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>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(314,500)	(6,000)	0	0	0	0	0	0	0	(320,500)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,853	0	0	0	0	0	0	0	0	0	7,853	19
20	Fees, Subscriptions & Promotions	(17,627)	0	0	0	0	0	0	0	0	0	0	(17,627)	20
21	Clerical & General Office Expenses	(77,629)	0	0	0	0	0	0	0	0	0	0	(77,629)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,602)	0	0	0	0	0	0	0	0	0	0	(1,602)	25
26	Insurance-Prop.Liab.Malpractice	0	105,894	0	0	0	0	0	0	0	0	0	105,894	26
27	Other (specify):*	0	0	4,793	2,636	0	0	0	0	0	0	0	7,429	27
28	<b>TOTAL General Administration</b>	<b>(96,858)</b>	<b>113,747</b>	<b>(309,707)</b>	<b>(3,364)</b>	<b>0</b>	<b>(296,182)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(97,578)</b>	<b>117,397</b>	<b>(309,707)</b>	<b>(3,364)</b>	<b>0</b>	<b>(293,252)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Nursing Home# 0038620

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

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

	Capital Expense	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>D. Ownership</b>													
30	Depreciation	(7,709)	58,116	0	0	0	0	0	0	0	0	0	50,407	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(37)	183,485	0	0	0	0	0	0	0	0	0	183,448	32
33	Real Estate Taxes	0	63,318	0	0	0	0	0	0	0	0	0	63,318	33
34	Rent-Facility & Grounds	0	(659,128)	0	0	0	0	0	0	0	0	0	(659,128)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	15,018	0	0	0	0	0	0	0	0	0	15,018	36
37	<b>TOTAL Ownership</b>	<b>(7,746)</b>	<b>(339,191)</b>	<b>0</b>	<b>(346,937)</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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(105,324)	(221,794)	(309,707)	(3,364)	0	0	0	0	0	0	0	(640,189)	45

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dan Shabat	100%	Waterford Nursing & Rehabilitation Centre	Chicago	Heritage Healthcare Centre LLC		Building Co
				Pharmore Drugs LLC		Drug Co
				Lifescan Laboratory Inc		Lab Co
				Pro Health Care Inc		Mgmt Co
				SFMA Inc		Mgmt Co

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 659,128	Heritage Healthcare Centre LLC	100.00%	\$	\$ (659,128)	1
2	V	32 Interest	570	" "		180,233	179,663	2
3	V	19 Accounting Fees		" "		4,275	4,275	3
4	V	6 Repairs & Maintenance		" "		3,650	3,650	4
5	V	26 Property Insurance		" "		105,894	105,894	5
6	V	33 R E Taxes		" "		63,318	63,318	6
7	V	30 Depreciation		" "		58,116	58,116	7
8	V	32 Amortization Loan Fees		" "		3,822	3,822	8
9	V	36 MIP Expense		" "		15,018	15,018	9
10	V	19 Legal Fees-Real Estate Tax				3,578	3,578	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 659,698			\$ 437,904	\$ * (221,794)	14

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

Facility Name & ID Number

Heritage Nursing Home

# 0038620

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management Fees	\$ 412,000	SFMA, INC		\$	\$ (412,000)
16	V	17 Dan Shabat Comp		" "		97,500	97,500
17	V	27 Admin Benefits		" "		4,793	4,793
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 412,000			\$ 102,293	\$ * (309,707)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management Fees	\$ 6,000	Pro Health Care Inc		\$	(6,000)
16	V	27 Salary - Stan Aron		" "		2,439	2,439
17	V	27 Payroll Taxes		" "		197	197
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 6,000			\$ 2,636	\$ * (3,364)

\* 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	10 In House Drugs	\$ 4,029	Pharmore Drugs LLC		\$ 4,029	\$	15
16	V	39 Exp - Drugs	47,740	" "		47,740		16
17	V	10 Pharmacy Consultant	4,080	" "		4,080		17
18	V							18
19	V							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		\$ 55,849			\$ 55,849	\$ *	39

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

Facility Name & ID Number

Heritage Nursing Home

# 0038620

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

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	39 Exp - Laboratory	\$ 1,157	Lifescan Laboratory Inc		\$ 1,157	\$	15
16	V							16
17	V							17
18	V							18
19	V							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		\$ 1,157			\$ 1,157	\$ *	39

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

Facility Name &amp; ID Number

Heritage Nursing Home

# 0038620

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dan Shabat	Owner	Administrative	100.00	See Attached	20	33.00	Alloc Salary	\$ 97,500	17-7	1
2	Stan Aron		Administrative	0.00	See Attached	1	2.44	Alloc Salary	2,439	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 99,939		13

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

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

Facility Name & ID Number Heritage Nursing Home

# 0038620

Report Period Beginning:

01/01/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

SFMA INC

Street Address

7520 North Skokie Blvd

City / State / Zip Code

Skokie, IL 60077

Phone Number

( 847) 982-1195

Fax Number

( 847) 982-0991

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.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Dan Shabat Comp	Avg Hours Worked	40	2	\$ 195,000	\$ 195,000	20	\$ 97,500	1
2	27	Admin Benefits	" "	40	2	9,586		20	4,793	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 204,586	\$ 195,000		\$ 102,293	25

Facility Name & ID Number Heritage Nursing Home

# 0038620

Report Period Beginning:

01/01/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salary - Stan Aron	Ave Hours Worked	41	4	\$ 100,000	1	\$ 2,439	1
2	27	Payroll Taxes	" "	41	4	8,087	1	197	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 108,087	\$ 100,000	\$ 2,636	25

Facility Name &amp; ID Number

Heritage Nursing Home

# 0038620

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

## 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		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	RELATED PARTY-Heritage Healthcare Centre LLC										1								
2	Heartland Bank		X	Mortgage	\$18,972.78	08/25/06	3,164,500	2,982,010	09/36	6.0000	180,233								
3	Loan Fees		X	Amortized over life of loan			114,655	98,094			3,822								
4											4								
5											5								
	<b>Working Capital</b>																		
6	Line of Credit		X	Working Capital	DEMAND					PRIME+	1,631								
7	Lexus Financial		X	Auto Loan	\$803.75	10/13/10	26,804	25,463	10/27/13	4.9000	267								
8											8								
9	TOTAL Facility Related				\$19,776.53		\$ 3,305,959	\$ 3,105,567			\$ 185,953								
	<b>B. Non-Facility Related*</b>																		
10	IDR		X	LATE FEES							37								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related						\$	\$			\$ 37								
15	TOTALS (line 9+line14)						\$ 3,305,959	\$ 3,105,567			\$ 185,990								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 15,018 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																						
1. Real Estate Tax accrual used on 2009 report.		\$	<b>138,761</b>	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.)		\$	<b>104,396</b>	2																				
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(34,365)</b>	3																				
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>107,528</b>	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 \$ <u>9,845</u> For <u>2007</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>(9,845)</b>	6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>63,318</b>	7																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2005	<u>138,155</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="3" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2009</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2009	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>FOR BHF USE ONLY</b>																								
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2006	<u>152,348</u>	9																					
	2007	<u>133,381</u>	10																					
	2008	<u>134,720</u>	11																					
	2009	<u>104,396</u>	12																					
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL</b>																								
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.</b>																								

**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.**



Facility Name & ID Number Heritage Nursing Home

# 0038620

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 84,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

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

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: \_\_\_\_\_ 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>RELATED PARTY - Heritage Healthcare Centre, LLC</u>		<u>1991</u>	<u>\$ 105,600</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 105,600</b>	<b>3</b>

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
FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	128	1991	1,878,400	48,164	39	48,164		961,275
5								
6								
7								
8								
Improvement Type**								
9								
10		1983	6,069		15			6,069
11		1984	2,054		10			2,054
12		1985	3,700		10			3,700
13		1985	5,594		10			5,594
14		1986	5,000		10			5,000
15		1987	2,250		10			2,250
16		1988	6,084		10			6,084
17		1990	4,919		10			4,919
18		1991	118,564		10			118,564
19		1991	6,809		10			6,809
20		1992	12,811		10			12,811
21		1992	8,947		10			8,947
22	Nurses station	2007	43,252	4,324	10	4,324		15,222
23	5 flat grilles with borders	2007	392	79	5	79		268
24	Seal coating and paint parking lot	2007	21,260	1,416	15	1,416		4,724
25	Replacement of door handles	2007	14,908	2,981	5	2,981		9,938
26	Reception area-door,glass wall,countertop,carpeting,painting	2010	13,340	889	10	889		889
27	Sewer Line	2010	4,500	263	10	263		
28								
29								
30								
31								
32								
33								
34								
35								
36								

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Nursing Home# 0038620

Report Period Beginning:

01/01/2010 Ending: 12/31/2010

**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	<b>FACILITY:</b>		\$	\$		\$	\$	\$	37
38	Various	1993	22,988		15			22,988	38
39	Various	1994	22,000	1,000	20	1,000		18,168	39
40	Various	1994	19,790	100	15	100		19,473	40
41	Various	1995	3,300	73	15	73		3,300	41
42	Various	1995	1,640		10			1,640	42
43	Various	1995	59,530	2,975	20	2,975		45,781	43
44	Various	1996	83,406	4,171	20	4,171		61,613	44
45	Various	1997	4,851		7			4,851	45
46	Various	1997	25,361	1,269	20	1,269		17,595	46
47	Various	2000	5,357	42	20	42		4,944	47
48	Various	2002	13,354	1,336	10	1,336		11,676	48
49	Various	2004	33,850	3,385	10	3,385		20,874	49
50									50
51	Wallcoverings and Flooring	2005	85,222	5,681	15	5,681		28,825	51
52	Install Water Coils	2005	21,675	3,251	5	3,251		21,675	52
53	Paint and Custom Replacement Baseboard Covers	2007	1,803	360	5	360		1,142	53
54	Nurses Station	2007	3,790	379	10	379		1,200	54
55	1st, 2nd and 3rd Floor Nurses Stations	2007	10,000	1,000	10	1,000		3,333	55
56	Nurses Station Sprinkler Head Improvements	2007	2,207	220	10	220		698	56
57	Barker Metalcraft	2008	1,803	181	10	181		466	57
58	Doors Done Right - Door, Frame and Heavy Duty Closer	2008	2,181	146	15	146		376	58
59	Walkin Cooler/Freezer	2008	20,505	4,101	20	4,101		9,227	59
60	Install Walkin Cooler/Freezer	2009	10,791	2,158	5	2,158		4,316	60
61	Cable Hardware & installation Resident & Day Rooms	2009	10,850	1,085	10	1,085		2,080	61
62	Repair Elevator Door	2009	8,675	316	27.5	316		631	62
63	Fire Alarm & Sprinkler System Repairs	2009	3,202	116	27.5	116		223	63
64	Hot Water Coil & Boiler Repairs	2009	5,693	207	27.5	207		281	64
65	"LG" Mini Split System For Kitchen	2009	5,029	183	27.5	183		274	65
66	Replace Front East Gate	2009	1,950	71	27.5	71		106	66
67	Steel Frame & Door	2009	1,891	69	27.5	69		86	67
68	Electrical Work & Motors for Exhaust Fans	2009	4,080	149	27.5	149		214	68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 2,655,627	\$ 92,140		\$ 92,140	\$	\$ 1,483,173	70

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

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	\$ 86,942	\$ 6,281	\$ 6,281	\$	5 - 10 Yrs	\$ 294,223	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	218,661				5 - 10 Yrs	218,661	73
74	RELATED PARTY-Heritage Healthcare Centre, LLC	247,414				5 - 10 Yrs	247,414	74
75	TOTALS	\$ 553,017	\$ 6,281	\$ 6,281	\$		\$ 760,298	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	ADMINISTRATIVE	2011 LEXUS 4D	2010	\$ 26,804	\$ 11,060	\$ 3,351	\$ (7,709)	4 YRS	\$ 3,351	76
77										77
78										78
79										79
80	TOTALS			\$ 26,804	\$ 11,060	\$ 3,351	\$ (7,709)		\$ 3,351	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)	\$ 3,341,048	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 109,481	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,772	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,709)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,246,822	85

\*\*

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 427 Description: POSTAGE METER RENTAL

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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 type="checkbox"/> YES <input checked="" 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="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</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	39-3	hrs	\$		\$ 57,309	\$		\$ 57,309	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			29,622			29,622	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			73,170			73,170	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				47,740		47,740	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	39-3				432			432	12
13	Other (specify): <u>Lab, Med Supplies</u>	39-2					13,716		13,716	13
14	TOTAL			\$		\$ 160,533	\$ 61,456		\$ 221,989	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 Nursing Home# 0038620Report Period Beginning: 01/01/2010Ending: 12/31/2010

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 223,944	\$ 276,360	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>422,722</u> )	515,265	515,265	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,741	71,388	6
7	Other Prepaid Expenses	400	9,602	7
8	Accounts Receivable (owners or related parties)	742,909		8
9	Other(specify): <u>Employee Loans &amp; Advances</u>	3,591	3,591	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,502,850	\$ 876,206	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,600	13
14	Buildings, at Historical Cost		1,878,400	14
15	Leasehold Improvements, at Historical Cost	496,774	788,583	15
16	Equipment, at Historical Cost	332,407	623,658	16
17	Accumulated Depreciation (book methods)	(613,339)	(2,034,495)	17
18	Deferred Charges		98,094	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		592,663	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>SECURITY DEPOSIT</u>	5,000		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 220,842	\$ 2,052,503	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,723,692	\$ 2,928,709	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 151,336	\$ 185,209	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,858	5,858	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,125	106,125	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,983	5,983	31
32	Accrued Real Estate Taxes(Sch.IX-B)		107,528	32
33	Accrued Interest Payable		14,910	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Due to Related Parties</u>	669,926	304,626	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 939,228	\$ 730,239	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	25,463	25,463	39
40	Mortgage Payable		2,982,010	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>	\$ 25,463	\$ 3,007,473	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 964,691	\$ 3,737,712	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 759,001	\$ (809,003)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,723,692	\$ 2,928,709	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>704,327</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING</b>	<b>7</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>704,334</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>54,667</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>54,667</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>759,001</b>	<b>24</b> *

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

Facility Name & ID Number Heritage Nursing Home# 0038620Report Period Beginning: 01/01/2010Ending: 12/31/2010**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	\$ 4,653,275	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,653,275	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	70,774	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 70,774	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,724,049	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	816,631	31
32	Health Care	1,532,044	32
33	General Administration	1,312,318	33
<b>B. Capital Expense</b>			
34	Ownership	712,855	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	221,989	35
36	Provider Participation Fee	70,080	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,665,917	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	58,132	41
42	<b>Income Taxes</b>	(3,465)	42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 54,667	43

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

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

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

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

Facility Name & ID Number **Heritage Nursing Home**

# **0038620**

Report Period Beginning: **01/01/2010**

Ending:

**12/31/2010**

**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	1,883	2,489	\$ 78,186	\$ 31.41	1
2	Assistant Director of Nursing	1,893	2,078	62,968	30.30	2
3	Registered Nurses	10,165	11,006	273,933	24.89	3
4	Licensed Practical Nurses	13,147	14,325	341,292	23.82	4
5	CNAs & Orderlies	45,226	63,299	528,195	8.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	926	965	11,806	12.23	8
9	Activity Director					9
10	Activity Assistants	6,788	8,302	84,128	10.13	10
11	Social Service Workers	1,864	2,088	39,030	18.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,120	21,358	209,845	9.83	15
16	Dishwashers					16
17	Maintenance Workers	2,024	2,244	38,023	16.94	17
18	Housekeepers	12,006	15,104	134,529	8.91	18
19	Laundry	2,841	3,205	29,264	9.13	19
20	Administrator	1,972	2,394	66,821	27.91	20
21	Assistant Administrator					21
22	Other Administrative	1,965	2,386	127,253	53.33	22
23	Office Manager					23
24	Clerical	11,064	12,142	200,328	16.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,884	163,385	\$ 2,225,601 *	\$ 13.62	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 5,280	1-3	35
36	Medical Director	O	11,000	9-3	36
37	Medical Records Consultant	N	1,568	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	4,080	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,600	11-3	44
45	Social Service Consultant	E	4,458	12-3	45
46	Other(specify) <u>Psycho-social</u>	S	850	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,836		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	571	21,379	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	571	\$ 21,379		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	
Thomas Dean	ADMINISTRATOR		\$ 66,821	Workers' Compensation Insurance	\$ 36,333	IDPH License Fee	\$ 1,990	
Sylvia Herlihy	EXEC DIRECTOR		127,253	Unemployment Compensation Insurance	18,974	Advertising: Employee Recruitment	2,320	
				FICA Taxes	169,011	Health Care Worker Background Check	1,400	
				Employee Health Insurance	113,594	(Indicate # of checks performed _____)		
				Employee Meals	24,273	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	6,213	
				EMPLOYEE BENEFITS - OTHER	0	MARKETING/ADV/PROMO	11,414	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	8,586	
				PENSION/PROFIT SHARING PLANS	16,695	MGMT CO ALLOC		
				CHICAGO HEAD TAX	4,524	TRUST/FRANCHISE/CONTRIB/ETC	(6,213)	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense	(11,414)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	( 0 )	
						Yellow page advertising	( 0 )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 194,074	TOTAL (agree to Schedule V, line 22, col.8)	\$ 383,404	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,296	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - SFMA			\$ 412,000				Out-of-State Travel	\$
Management Fees - Pro Health			6,000					
							In-State Travel	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 418,000				Seminar Expense	0
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
			\$					
SEE SCHEDULE ATTACHED			78,244					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 78,244					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Heritage Nursing Home

# 0038620

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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ICLTC \$6,560 IAHC \$1,536
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,149 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Heritage Healthcare Center License #38620 Through 11/01/1992
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 70,080  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 24,273 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? NONE  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.