

Facility Name & ID Number Heritage Fifty-Three

0024836 Report Period Beginning: 7/1/10 Ending: 6/30/11

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	48	Intermediate/DD	48	17,520	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	48	TOTALS	48	17,520	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	Private Pay	4 Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	17,216			17,216	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,216			17,216	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.26%

D. How many bed-hold days during this year were paid by the Department? 304 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/13/79

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/13/79 NO

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

Medicare Intermediary No

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/11 Fiscal Year: 6/30/11

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

Facility Name & ID Number

Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	147,101	3,289	4,160	154,550		154,550		154,550		1
2	Food Purchase		133,229		133,229	(21,063)	112,166	155	112,321		2
3	Housekeeping	34,978	30,301	59,914	125,193		125,193	570	125,763		3
4	Laundry		5,830		5,830		5,830		5,830		4
5	Heat and Other Utilities			83,147	83,147		83,147	900	84,047		5
6	Maintenance	20,579	54,527	3,132	78,238		78,238	5,021	83,259		6
7	Other (specify):*										7
8	TOTAL General Services	202,658	227,176	150,353	580,187	(21,063)	559,124	6,646	565,770		8
	B. Health Care and Programs										
9	Medical Director			4,725	4,725		4,725		4,725		9
10	Nursing and Medical Records	1,242,579	57,553	435	1,300,567		1,300,567	6,840	1,307,407		10
10a	Therapy										10a
11	Activities		1,114		1,114		1,114		1,114		11
12	Social Services	92,349			92,349		92,349		92,349		12
13	CNA Training	53,150	553		53,703		53,703		53,703		13
14	Program Transportation		15,770		15,770		15,770		15,770		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,388,078	74,990	5,160	1,468,228		1,468,228	6,840	1,475,068		16
	C. General Administration										
17	Administrative	64,622			64,622		64,622	169,676	234,298		17
18	Directors Fees										18
19	Professional Services							14,599	14,599		19
20	Dues, Fees, Subscriptions & Promotions			12,265	12,265		12,265	11,437	23,702		20
21	Clerical & General Office Expenses	9,974	6,899	8,670	25,543		25,543	4,492	30,035		21
22	Employee Benefits & Payroll Taxes			402,404	402,404	21,063	423,467	38,522	461,989		22
23	Inservice Training & Education							194	194		23
24	Travel and Seminar			99	99		99	859	958		24
25	Other Admin. Staff Transportation		1,352		1,352		1,352	1,291	2,643		25
26	Insurance-Prop.Liab.Malpractice			22,417	22,417		22,417	2,059	24,476		26
27	Other (specify):*										27
28	TOTAL General Administration	74,596	8,251	445,855	528,702	21,063	549,765	243,129	792,894		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,665,332	310,417	601,368	2,577,117		2,577,117	256,615	2,833,732		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 (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			112,919	112,919		112,919	10,257	123,176			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							380	380			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			112,919	112,919		112,919	10,637	123,556			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,890	160,890		160,890		160,890			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			160,890	160,890		160,890		160,890			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,665,332	310,417	875,177	2,850,926		2,850,926	267,252	3,118,178			45

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

Heritage Fifty-Three

ID# 0024836

Report Period Beginning: 7/1/10

Ending: 6/30/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Fifty-Three# 0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	155	0	0	0	0	0	0	0	0	0	155	2
3	Housekeeping	0	570	0	0	0	0	0	0	0	0	0	570	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	900	0	0	0	0	0	0	0	0	0	900	5
6	Maintenance	0	5,021	0	0	0	0	0	0	0	0	0	5,021	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	6,646	0	0	0	0	0	0	0	0	0	6,646	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	6,840	0	0	0	0	0	0	0	0	0	6,840	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	6,840	0	0	0	0	0	0	0	0	0	6,840	16
	C. General Administration													
17	Administrative	0	169,676	0	0	0	0	0	0	0	0	0	169,676	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,599	0	0	0	0	0	0	0	0	0	14,599	19
20	Fees, Subscriptions & Promotions	0	11,437	0	0	0	0	0	0	0	0	0	11,437	20
21	Clerical & General Office Expenses	0	4,492	0	0	0	0	0	0	0	0	0	4,492	21
22	Employee Benefits & Payroll Taxes	0	38,522	0	0	0	0	0	0	0	0	0	38,522	22
23	Inservice Training & Education	0	194	0	0	0	0	0	0	0	0	0	194	23
24	Travel and Seminar	0	0	859	0	0	0	0	0	0	0	0	859	24
25	Other Admin. Staff Transportation	0	0	1,291	0	0	0	0	0	0	0	0	1,291	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,059	0	0	0	0	0	0	0	0	2,059	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	238,920	4,209	0	0	0	0	0	0	0	0	243,129	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	252,406	4,209	0	0	0	0	0	0	0	0	256,615	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Fifty-Three# 0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

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)	
	D. Ownership													
30	Depreciation	0	0	10,257	0	0	0	0	0	0	0	0	10,257	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	380	0	0	0	0	0	0	0	0	380	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	10,637	0	10,637	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	252,406	14,846	0	0	0	0	0	0	0	0	267,252	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	2 Food and Beverage	\$	ARCQCA	100.00%	\$ 155	\$	155	1
2	V	3 Housekeeping		ARCQCA	100.00%	570		570	2
3	V	5 Utilities		ARCQCA	100.00%	900		900	3
4	V	6 Maintenance		ARCQCA	100.00%	5,021		5,021	4
5	V	19 Account/Consult		ARCQCA	100.00%	8,338		8,338	5
6	V	19 Legal Fees		ARCQCA	100.00%	6,261		6,261	6
7	V	17 Administration Salaries		ARCQCA	100.00%	169,676		169,676	7
8	V	20 Sub/Promotion/Printing		ARCQCA	100.00%	11,437		11,437	8
9	V	21 Office Supplies		ARCQCA	100.00%	3,546		3,546	9
10	V	21 Telephone		ARCQCA	100.00%	946		946	10
11	V	22 Employment Benefits		ARCQCA	100.00%	38,522		38,522	11
12	V	10 Medical/Hygiene Supplies		ARCQCA	100.00%	6,840		6,840	12
13	V	23 Staff Training		ARCQCA	100.00%	194		194	13
14	Total		\$			\$ 252,406	\$ *	252,406	14

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

Facility Name & ID Number

Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

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	\$	ARCQCA	100.00%	\$ 859	\$	859	15
16	V	25 Other Administration, Staff Transportation		ARCQCA	100.00%	1,291		1,291	16
17	V	26 Insurance/Prof/Liability		ARCQCA	100.00%	2,059		2,059	17
18	V	32 Interest Mortgage		ARCQCA	100.00%	380		380	18
19	V	30 Depreciation		ARCQCA	100.00%	10,257		10,257	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		\$			\$ 14,846	\$ *	14,846	39

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

Facility Name & ID Number

Heritage Fifty-Three

#

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

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									\$		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

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Report Period Beginning:

7/1/10

Ending: 6/30/11

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 The Arc of the Quad Cities Area
 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	1,246,946	17 programs	\$ 585	\$ 329,895	\$ 155	1
2	3	Housekeeping	Administrative costs	1,246,946	17 programs	2,156	329,895	570	2
3	5	Utilities	are to be allocated	1,246,946	17 programs	3,400	329,895	900	3
4	6	Maintenance	based on percentage	1,246,946	17 programs	18,977	329,895	5,021	4
5	19	Accountant/Consultant	of salary	1,246,946	17 programs	31,518	329,895	8,338	5
6	19	Legal Fees		1,246,946	17 programs	23,665	329,895	6,261	6
7	17	Administrative Salaries		1,246,946	17 programs	641,346	329,895	169,676	7
8	20	Sub/Promotion/Printing		1,246,946	17 programs	43,231	329,895	11,437	8
9	21	Other Expense		1,246,946	17 programs	13,403	329,895	3,546	9
10	21	Telephone		1,246,946	17 programs	3,575	329,895	946	10
11	22	Employee Benefits		1,246,946	17 programs	145,606	329,895	38,522	11
12	10	Medical/Hygiene Supplies		1,246,946	17 programs	25,855	329,895	6,840	12
13	23	Staff Training		1,246,946	17 programs	733	329,895	194	13
14	24	Travel Seminar		1,246,946	17 programs	3,246	329,895	859	14
15	25	Other Administration/Staff Transportation		1,246,946	17 programs	4,878	329,895	1,291	15
16	26	Insurance/Prof/Liability		1,246,946	17 programs	7,784	329,895	2,059	16
17	32	Interest Mortgage		1,246,946	17 programs	1,438	329,895	380	17
18	30	Depreciation		1,246,946	17 programs	38,771	329,895	10,257	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,010,167	\$	\$ 267,252	25

Facility Name & ID Number

Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

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
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$			\$	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$	\$			\$	15							

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2010 report.		\$	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).		\$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2006	_____	8
	2007	_____	9
	2008	_____	10
	2009	_____	11
	2010	_____	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

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

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>DD Facility</u>	<u>196,020</u>	<u>1980</u>	<u>\$ 98,594</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	196,020		\$ 98,594	3

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

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

	1	2	3	4	5	6	7	8	9		
	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			1998	1998	9,995		31.5				5
6											6
7											7
8											8
		Improvement Type**									
9		Shower Renovation	1985		92,597	4,644	20	4,644		101,885	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		7,178	13
14		Roof Repair, Asphalt, Remodeling	1993		15,650	497	31.5	497		10,319	14
15		Plumbing repairs, Sidewalk Ramp	1994		8,220	261	31.5	261		7,951	15
16		Roof and Hot Water System	1995		22,625	718	31.5	718		21,585	16
17		New Hot Water System	1996		50,449	1,602	31.5	1,602		18,262	17
18		Hot Water Continuation	1997		35,175	1,116	31.5	1,116		16,182	18
19		Hot Water Continuation	1997		4,202	133	31.5	133		2,863	19
20		Parking Lot Blacktop	1997		3,430	109	31.5	109		5,567	20
21		Shopper Driveway, Fire Alarm, Water Tank Tub	1998		35,520	1,128	31.5	1,128		12,996	21
22		Air/Fire Doors, Concrete Walks, Fuel Storage Tanks	1999		35,720	1,134	31.5	1,134		10,778	22
23		8 Power Doors	2000		9,485	301	31.5	301		2,860	23
24		Automatic Doors	2000		9,989	317	31.5	317		3,329	24
25		Concrete Walks/5 Areas	2000		2,550	81	31.5	81		769	25
26		Electrical For Auto Doors	2000		1,414	45	31.5	45		472	26
27		Electrical For Auto Doors	2000		1,365	43	31.5	43		452	27
28		Install Whirlpool Tub	2000		7,320	232	31.5	232		2,436	28
29		Bedroom Remodel/Salary Expense	2000		1,169	37	31.5	37		389	29
30		Twin Furnaces	2000		5,520	175	31.5	175		1,838	30
31		Blacktop Parking Lot	2001		3,960	126	31.5	126		1,196	31
32		Air Conditioning Repairs	2001		1,411	45	31.5	45		427	32
33		Install 8 Furnace Units	2001		10,400	330	31.5	330		3,135	33
34		Install 2 Air Conditioning Units	2001		4,250	135	31.5	135		1,282	34
35		Install Air Conditioning Units in Kitchen	2001		1,750	56	31.5	56		532	35
36		Electrical for Home Theatre	2001		530	17	31.5	17		161	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Kick Plates/Door Guards	2001	\$ 900	\$ 29	31.5	\$ 29		\$ 275	37
38	Concrete Sidewalk/Ramp	2002	3,525	112	31.5	112		952	38
39	Install 2 Air Conditioning Units	2002	2,125	67	31.5	67		570	39
40	Install 5 Fire Doors	2002	643	20	31.5	20		170	40
41	Motor for Air Conditioning Unit	2002	500	16	31.5	16		136	41
42	Re-tile Floors	2002	18,750	595	31.5	595		5,058	42
43	Install 4 Wood Fire Doors	2002	546	17	31.5	17		145	43
44	Install Accordion Door	2002	4,495	143	31.5	143		1,072	44
45	Install Kitchen Hood Exhaust Fan	2002	2,114	67	31.5	67		570	45
46	Install 8 Countertop	2002	1,140	36	31.5	36		306	46
47	Install Sensory Room/Electrical Work	2002	1,606	51	31.5	51		433	47
48	Grease Trap	2004	3,640	116	31.5	116		870	48
49	Repairs to Automatic Doors	2004	2,805	89	31.5	89		668	49
50	Sewer Repairs	2004	3,537	112	31.5	112		840	50
51	Re-tile Kitchen Floor	2004	2,158	69	31.5	69		517	51
52	Sensory Room Electrical Work	2004	1,425	45	31.5	45		406	52
53	Install Air Conditioning Unit	2005	2,035	64	31.5	64		416	53
54	Update Fire System in Kitchen	2005	2,345	74	31.5	74		481	54
55	Install 29 Windows	2005	9,831	312	31.5	312		2,028	55
56	Install Whirlpool Tub	2005	2,898	92	31.5	92		598	56
57	Concrete Sidewalks	2005	3,650	116	31.5	116		754	57
58	Kitchen Cabinets	2005	4,705	149	31.5	149		969	58
59	Install Bathroom Tiles	2005	4,155	132	31.5	132		858	59
60	Install Lights/Electrical Work	2005	10,120	321	31.5	321		2,087	60
61	Install Ceiling Tiles/Drywall	2005	21,746	690	31.5	690		4,485	61
62	Building Renovations/RV	2006	62,226	1,975	31.5	1,975		10,863	62
63	Building Renovations/BV	2006	5,703	181	31.5	181		996	63
64	Install Fence around 4 Buildings	2006	9,630	306	31.5	306		1,683	64
65	Concrete Patios/RV	2006	5,450	173	31.5	173		952	65
66	Concrete Patios/ER	2006	6,100	194	31.5	194		1,067	66
67	Commercial Garbage Disposal/Main Kitchen	2006	1,571	50	31.5	50		275	67
68	Replace Mixing Valves	2006	2,773	88	31.5	88		484	68
69	Remodel PT Room	2006	13,283	422	31.5	422		2,321	69
70	TOTAL (lines 4 thru 69)		\$ 627,989	\$ 20,421		\$ 20,421	\$	\$ 307,504	70

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

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning:

7/1/10

Ending:

6/30/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 627,989	\$ 20,421		\$ 20,421	\$	\$ 307,504	1
2	Generator Repairs	2007	1,244	39	31.5	39		176	2
3	Install New Bedroom and Bathroom Doors	2007	6,611	210	31.5	210		945	3
4	Re-Tile Main Building Office/Hallways	2007	4,175	133	31.5	133		598	4
5	Sidewalk Repair between LW/RV	2007	1,200	38	31.5	38		171	5
6	New Fence around all buildings	2007	13,267	421	31.5	421		1,895	6
7	Install Fire Wall	2007	850	27	31.5	27		121	7
8	Build/Repair Walls	2007	1,400	44	31.5	44		198	8
9	Repair 3 doors BV	2007	680	22	31.5	22		99	9
10	Install Air Conditioning Unit in Kitchen	2007	2,900	92	31.5	92		414	10
11	Install 22 Windows LW	2007	8,360	265	31.5	265		1,193	11
12	Replace door and lock RV	2007	990	31	31.5	31		140	12
13	Clean Mixing Valves	2007	6,519	207	31.5	207		931	13
14	Install Kitchen Cabinets LW	2007	1,269	40	31.5	40		180	14
15	Repair Hot Water Heater RV	2007	1,578	50	31.5	50		225	15
16	Install 3 Soft Lite Windows	2007	1,259	40	31.5	40		180	16
17	Blacktop Front Circle Drive	2008	2,700	86	31.5	86		301	17
18	Repair Ducts in Main office building	2008	1,056	34	31.5	34		119	18
19	Install 16KW Generator	2008	13,200	419	31.5	419		1,467	19
20	Electrical Work/Main Office Building	2008	931	30	31.5	30		105	20
21	Wall/Plaster Repair Riverview	2008	1,125	36	31.5	36		126	21
22	Plumbing Work/Laundry facilities Riverview	2008	1,596	51	31.5	51		178	22
23	Clean Vents/Ducts Birchview	2008	965	31	31.5	31		108	23
24	Plumbing Work/Laundry & Sink hookup birchview	2008	1,023	32	31.5	32		112	24
25	RegROUT Showers Birchview	2008	1,000	32	31.5	32		112	25
26	Install 4 Windows Birchview	2008	1,440	46	31.5	46		161	26
27	Install Closet Doors Birchview	2008	1,912	61	31.5	61		213	27
28	Install 4 Double Dresser Birchview	2008	3,680	117	31.5	117		409	28
29	Install Light Fixtures Birchview	2008	2,450	78	31.5	78		273	29
30	New Roof Birchview	2008	17,460	554	31.5	554		1,939	30
31	Wall/Plaster Repair Lakewood Remodel	2008	2,440	77	31.5	77		270	31
32	Wall Protectors and Installation Lakewood Remodel	2008	6,398	203	31.5	203		711	32
33	Install Bathroom Countertop/Towel bar Lakewood Remodel	2008	1,590	50	31.5	50		175	33
34	TOTAL (lines 1 thru 33)		\$ 741,257	\$ 24,017		\$ 24,017	\$	\$ 321,749	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:

7/1/10

Ending:

6/30/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 741,257	\$ 24,017		\$ 24,017	\$	\$ 321,749	1
2	Tile/Grout work Kitchen Lakewood Remodel	2008	846	27	31.5	27		94	2
3	RegROUT Showers Lakewood Remodel	2008	2,000	63	31.5	63		221	3
4	New Window Blinds Lakewood Remodel	2008	5,041	160	31.5	160		560	4
5	Painting Lakewood Remodel	2008	1,905	60	31.5	60		210	5
6	Install Built-In Bedroom Dressers Lakewood Remodel	2008	3,640	116	31.5	116		406	6
7	Install 17 Windows Lakewood Remodel	2008	6,120	194	31.5	194		679	7
8	Install 8 Bathroom Mirrors Lakewood Remodel	2008	982	31	31.5	31		109	8
9	New Tile Flooring Lakewood	2008	2,267	72	31.5	72		252	9
10	Install New Bathroom Sinks/Drains Lakewood Remodel	2008	6,386	203	31.5	203		710	10
11	Install 16 Closet Doors Lakewood Remodel	2008	7,648	242	31.5	242		847	11
12	Laminate 5 Med Closet Doors Lakewood Remodel	2008	1,090	35	31.5	35		122	12
13	Relaminate doors Lakewood remodel	2008	4,270	136	31.5	136		476	13
14	Install New Doors/Frames Lakewood Remodel	2008	5,050	160	31.5	160		560	14
15	Electrical Work/Install Light Fixtures Lakewood Remodel	2008	15,892	505	31.5	505		1,767	15
16	Hardware supplies Lakewood Remodel	2008	1,933	61	31.5	61		214	16
17	Clean Vents/Ducts Lakewood	2008	965	31	31.5	31		108	17
18	Sidewalk Repair Lakewood	2008	7,050	224	31.5	224		784	18
19	New Roof on Riverview	2009	13,337	423	31.5	423		1,058	19
20	Install Handrails in Lakewood	2009	3,295	105	31.5	105		262	20
21	New Roof on Lakewood	2009	13,337	423	31.5	423		1,058	21
22	New Roof Main Building	2009	13,337	423	31.5	423		1,058	22
23	Concrete Work/Sidewalk Repair Main Building	2009	8,250	262	31.5	262		655	23
24	Underground Storage Tank	2009	1,134	36	31.5	36		90	24
25	Install new Ceiling Grid in Kitchen Main building	2009	735	23	31.5	23		58	25
26	Install Additional Fire System Main Building	2009	5,384	171	31.5	171		427	26
27	New Shed	2009	1,506	48	31.5	48		120	27
28	New Tile Floor Main Building	2009	498	16	31.5	16		40	28
29	Repair Air Conditioning Units	2009	1,692	54	31.5	54		135	29
30	Repair Gutters Main Building	2009	1,150	37	31.5	37		92	30
31	Build Block Wall Main building	2009	750	24	31.5	24		60	31
32	Install Circulating Pump Main Building	2009	1,466	47	31.5	47		117	32
33	Water Main Break Repairs Main Building	2009	11,806	375	31.5	375		937	33
34	TOTAL (lines 1 thru 33)		\$ 892,019	\$ 28,804		\$ 28,804	\$	\$ 336,035	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:

7/1/10

Ending:

6/30/11

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 892,019	\$ 28,804		\$ 28,804	\$	\$ 336,035	1
2	Plumbing repairs Main Building	2009	764	24	31.5	24		60	2
3	Install Generator/AMP Meter to Birchview	2009	11,000	349	31.5	349		873	3
4	Repairs to Fire Alarm Box in Birchview	2009	1,128	36	31.5	36		90	4
5	Install Vanities/Sinks in Bathrooms Birchview Remodel	2009	10,251	325	31.5	325		813	5
6	Built-In Closet and Dressers Birchview remodel	2009	18,516	588	31.5	588		1,470	6
7	Install Vertical Blinds Birchview Remodel	2009	3,390	108	31.5	108		270	7
8	Install New Lights Birchview Remodel	2009	9,907	315	31.5	315		787	8
9	Install Exterior Door Birchview Remodel	2009	1,286	41	31.5	41		102	9
10	Install/Re-laminate doors Birchview Remodel	2009	5,322	169	31.5	169		422	10
11	Install New Doors Locks Birchview Remodel	2009	1,349	43	31.5	43		107	11
12	Install 9 Mirrors Birchview Remodel	2009	1,140	36	31.5	36		90	12
13	Install Corner Boards/Cove Base Birchview Remodel	2009	4,353	138	31.5	138		345	13
14	Supplies for Birchview Remodel	2009	1,144	36	31.5	36		90	14
15	Concrete Work Birchview Remodel	2009	2,250	71	31.5	71		178	15
16	Kitchen Remodel/Install Backsplash Birchview Remodel	2009	5,909	188	31.5	188		470	16
17	Plumbing Work Birchview Remodel	2009	2,050	65	31.5	65		163	17
18	Baseboard Heat Birchview	2009	610	19	31.5	19		48	18
19	Electrical Work Birchview Remodel	2009	2,354	75	31.5	75		187	19
20	Concrete Pad for Generator H53	2010	1,700	54	31.5	54		81	20
21	Tile Showers area H53	2010	614	19	31.5	19		29	21
22	Generator for Birchview	2010	6,125	194	31.5	194		291	22
23	Electrical Work for Generator Birchview H53	2010	3,000	95	31.5	95		143	23
24	Siding Lakewood	2010	17,500	556	31.5	556		834	24
25	Compressors for Air Conditioning Units at Lakewood	2010	3,844	122	31.5	122		183	25
26	Concrete Sidewalks/Drive Apron at H53	2010	5,700	181	31.5	181		271	26
27	New Siding all buildings	2011	68,494	1,087	31.5	1,087		1,087	27
28	Engineering/Sprinkler System	2011	11,060	176	31.5	176		176	28
29	Architect Services	2011	1,000	16	31.5	16		16	29
30	Repair 6 doors LW	2011	1,058	17	31.5	17		17	30
31	Install 100 Gallon Hot Water Heater	2011	3,275	52	31.5	52		52	31
32	Install 3 Air Conditioning Units	2011	5,264	84	31.5	84		84	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,103,376	\$ 34,083		\$ 34,083	\$	\$ 345,864	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:

7/1/10

Ending:

6/30/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 563,186	\$ 77,265	\$ 77,265	\$	10	\$ 431,984	71
72	Current Year Purchases	46,275	4,628	4,628		10	4,628	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 609,461	\$ 81,893	\$ 81,893	\$		\$ 436,612	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2008 Chevy Uplander	2008	\$ 36,000	\$ 7,200	\$ 7,200	\$	5	\$ 25,200	76
77										77
78										78
79										79
80	TOTALS			\$ 36,000	\$ 7,200	\$ 7,200	\$		\$ 25,200	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)	\$ 1,847,431	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 123,176	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 123,176	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)	\$ 807,676	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: _____

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

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

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

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>55</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></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	55	498		553
3	Classroom Wages (a)	468	10,177		10,645
4	Clinical Wages (b)	822	14,803		15,625
5	In-House Trainer Wages (c)	2,688	24,192		26,880
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 4,033	\$ 49,670	\$	\$ 53,703
10	SUM OF line 9, col. 1 and 2 (e)	\$ 53,703			

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	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	20

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

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

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

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

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Fifty-Three

0024836

Report Period Beginning: 7/1/10

Ending: 6/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/11 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 932,496	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	702,072		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,503		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,637,071	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	98,594		13
14	Buildings, at Historical Cost	1,103,376		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	645,461		16
17	Accumulated Depreciation (book methods)	(807,676)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,039,755	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,676,826	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 91,462	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	397,140		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	81,804		34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 570,406	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 570,406	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,106,420	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,676,826	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,939,868	1
2	Restatements (describe):	(30,138)	2
3	Fixed Asset Reclassification		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,909,730	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	196,690	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)	\$ 196,690	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,106,420	24 *

* This must agree with page 17, line 47.

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,872,505	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,872,505	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	482	9
10	Other Government Grants	8,356	10
11	CNA Training Reimbursements	26,491	11
12	Gift and Coffee Shop	2,731	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,524	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	28,879	21
22	Laundry	17,107	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 88,570	23
D. Non-Operating Revenue			
24	Contributions	81,469	24
25	Interest and Other Investment Income***	5,072	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 86,541	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,047,616	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	580,187	31
32	Health Care	1,468,228	32
33	General Administration	528,702	33
B. Capital Expense			
34	Ownership	112,919	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	160,890	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,850,926	40
41	Income before Income Taxes (line 30 minus line 40)**	196,690	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 196,690	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:

7/1/10

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6/30/11

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	1,618	\$ 39,225	\$ 24.24	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses	14,577	257,097	17.64	4
5	CNAs & Orderlies				5
6	CNA Trainees	2,521	26,270	10.42	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	29,594	14.23	13
14	Head Cook				14
15	Cook Helpers/Assistants	12,586	117,507	9.34	15
16	Dishwashers				16
17	Maintenance Workers	989	20,579	20.81	17
18	Housekeepers	3,662	34,978	9.55	18
19	Laundry				19
20	Administrator	2,496	64,622	25.89	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager	420	5,637	13.42	23
24	Clerical	324	4,337	13.39	24
25	Vocational Instruction				25
26	Academic Instruction	1,319	26,880	20.38	26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	5,596	92,349	16.50	28
29	Resident Services Coordinator	9,904	148,257	14.97	29
30	Habilitation Aides (DD Homes)	76,583	798,000	10.42	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	134,675	\$ 1,665,332 *	\$ 12.37	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	83	\$ 4,160	L1C3	35
36	Medical Director				36
37	Medical Records Consultant	Annual	4,725	L9C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	9	435	L10C3	39
40	Physical Therapy Consultant				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)	92	\$ 9,320		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function				Description	Amount	Description	Amount		
Susan Smith	Administrator		\$ 53,856	Workers' Compensation Insurance	\$ 52,060	IDPH License Fee	\$ 4,225			
Julie Williams	Assoc. Ex. Dir.		10,766	Unemployment Compensation Insurance	6,053	Advertising: Employee Recruitment	9,729			
				FICA Taxes	138,803	Health Care Worker Background Check				
				Employee Health Insurance	78,736	(Indicate # of checks performed <u>0</u>)	0			
				Employee Meals	21,063	Patient Background Checks	62			
				Illinois Municipal Retirement Fund (IMRF)*		Arc of IL and US Dues	3,800			
				Pension Expense Employer Paid	120,715	Staff Awards and Promotions, Advocacy	4,067			
				Disability Insurance	2,751	Subscriptions	151			
				Group Term Insurance	2,702	Direct Deposit Fees	800			
				Admin Fringe Benefits from schedule VIII line 11 c9	38,522					
				Immunization Costs	585	Less: Public Relations Expense	()			
						Non-allowable advertising	()			
						Yellow page advertising	()			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 64,622	TOTAL (agree to Schedule V, line 22, col.8)		\$ 461,989		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 23,702
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description				Description	Line #	Amount	Description	Amount		
			\$			\$	Out-of-State Travel	\$		
							In-State Travel	958		
							Seminar Expense			
							Entertainment Expense	()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 958	
C. Professional Services			Amount							
Vendor/Payee	Type			Description	Line #	Amount	Description	Amount		
			\$			\$				
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$	TOTAL		\$				

* Attach copy of IMRF notifications

**See instructions.

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Report Period Beginning:

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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? 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. \$ 160,890
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. \$ 21,063 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
- (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.