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.

I. IDPH License ID Number: 0024836

Facility Name: Heritage Fifty-Three

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

County: Rock Island

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 503c

In the event there are further questions about this report, please contact:
Name: David Daughtery **Telephone Number:** 309 786-6474
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/09 to 6/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Stacey Cary
(Title) Associate Executive Director

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	17,240			17,240	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,240			17,240	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.40%

D. How many bed-hold days during this year were paid by the Department?
280 (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 [X]

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

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 [X] Date 11/13/79 NO [ ]

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

Medicare Intermediary No

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	153,040	3,105	4,506	160,651		160,651		160,651			1
2	Food Purchase		134,755		134,755	(20,650)	114,105	51	114,156			2
3	Housekeeping	48,854	27,832	30,883	107,569		107,569	3,477	111,046			3
4	Laundry		4,671		4,671		4,671		4,671			4
5	Heat and Other Utilities			70,495	70,495		70,495	1,217	71,712			5
6	Maintenance	19,980	54,714	8,955	83,649		83,649	3,754	87,403			6
7	Other (specify):*											7
8	TOTAL General Services	221,874	225,077	114,839	561,790	(20,650)	541,140	8,499	549,639			8
	B. Health Care and Programs											
9	Medical Director			4,725	4,725		4,725		4,725			9
10	Nursing and Medical Records	1,302,390	13,527	479	1,316,396		1,316,396	796	1,317,192			10
10a	Therapy											10a
11	Activities		1,093		1,093		1,093		1,093			11
12	Social Services	91,371			91,371		91,371		91,371			12
13	CNA Training	33,878	325		34,203		34,203		34,203			13
14	Program Transportation		13,393		13,393		13,393		13,393			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,427,639	28,338	5,204	1,461,181		1,461,181	796	1,461,977			16
	C. General Administration											
17	Administrative	60,643			60,643		60,643	151,776	212,419			17
18	Directors Fees											18
19	Professional Services							15,426	15,426			19
20	Dues, Fees, Subscriptions & Promotions			6,807	6,807		6,807	7,061	13,868			20
21	Clerical & General Office Expenses	12,236	7,444	9,028	28,708		28,708	5,915	34,623			21
22	Employee Benefits & Payroll Taxes			375,634	375,634	20,650	396,284	40,602	436,886			22
23	Inservice Training & Education							72	72			23
24	Travel and Seminar			776	776		776	522	1,298			24
25	Other Admin. Staff Transportation		1,903		1,903		1,903	1,239	3,142			25
26	Insurance-Prop.Liab.Malpractice			24,503	24,503		24,503	2,170	26,673			26
27	Other (specify):*											27
28	TOTAL General Administration	72,879	9,347	416,748	498,974	20,650	519,624	224,783	744,407			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,722,392	262,762	536,791	2,521,945		2,521,945	234,078	2,756,023			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Fifty-Three #0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			109,797	109,797		109,797	8,943	118,740			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			109,797	109,797		109,797	8,943	118,740			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			158,936	158,936		158,936		158,936			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			158,936	158,936		158,936		158,936			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,722,392	262,762	805,524	2,790,678		2,790,678	243,021	3,033,699			45

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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

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.)

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

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	243,021		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 243,021		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 243,021		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heritage Fifty-Three

ID# 0024836

Report Period Beginning: 7/1/09

Ending: 6/30/10

	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:** 7/1/09 **Ending:** 6/30/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	51	0	0	0	0	0	0	0	0	0	51	2
3	Housekeeping	0	3,477	0	0	0	0	0	0	0	0	0	3,477	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,217	0	0	0	0	0	0	0	0	0	1,217	5
6	Maintenance	0	3,754	0	0	0	0	0	0	0	0	0	3,754	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	8,499	0	0	0	0	0	0	0	0	0	8,499	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	796	0	0	0	0	0	0	0	0	0	796	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	796	0	0	0	0	0	0	0	0	0	796	16
	C. General Administration													
17	Administrative	0	151,776	0	0	0	0	0	0	0	0	0	151,776	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,426	0	0	0	0	0	0	0	0	0	15,426	19
20	Fees, Subscriptions & Promotions	0	7,061	0	0	0	0	0	0	0	0	0	7,061	20
21	Clerical & General Office Expenses	0	5,915	0	0	0	0	0	0	0	0	0	5,915	21
22	Employee Benefits & Payroll Taxes	0	40,602	0	0	0	0	0	0	0	0	0	40,602	22
23	Inservice Training & Education	0	72	0	0	0	0	0	0	0	0	0	72	23
24	Travel and Seminar	0	0	522	0	0	0	0	0	0	0	0	522	24
25	Other Admin. Staff Transportation	0	0	1,239	0	0	0	0	0	0	0	0	1,239	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,170	0	0	0	0	0	0	0	0	2,170	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	220,852	3,931	0	0	0	0	0	0	0	0	224,783	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	230,147	3,931	0	0	0	0	0	0	0	0	234,078	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Heritage Fifty-Three** **# 0024836** **Report Period Beginning:** **7/1/09** **Ending:** **6/30/10**

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	8,943	0	0	0	0	0	0	0	0	8,943	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	8,943	0	0	0	0	0	0	0	0	8,943	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	230,147	12,874	0	0	0	0	0	0	0	0	243,021	45

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food and Beverage	$	ARCRIC	100.00%	$ 51	$ 51	1
2	V	3	Housekeeping		ARCRIC	100.00%	3,477	3,477	2
3	V	5	Utilities		ARCRIC	100.00%	1,217	1,217	3
4	V	6	Maintenance		ARCRIC	100.00%	3,754	3,754	4
5	V	19	Account/Consult		ARCRIC	100.00%	11,682	11,682	5
6	V	19	Legal Fees		ARCRIC	100.00%	3,744	3,744	6
7	V	17	Administration Salaries		ARCRIC	100.00%	151,776	151,776	7
8	V	20	Sub/Promotion/Printing		ARCRIC	100.00%	7,061	7,061	8
9	V	21	Office Supplies		ARCRIC	100.00%	4,905	4,905	9
10	V	21	Telephone		ARCRIC	100.00%	1,010	1,010	10
11	V	22	Employee Benefits		ARCRIC	100.00%	40,602	40,602	11
12	V	10	Medical/Hygiene Supplies		ARCRIC	100.00%	796	796	12
13	V	23	Staff Training		ARCRIC	100.00%	72	72	13
14	Total			$			$ 230,147	$ * 230,147	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: 7/1/09 Ending: 6/30/10

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	24	Travel Seminar	$	ARCRIC	100.00%	$ 522	$ 522	15
16	V	25	Other Administration, Staff Transportation		ARCRIC	100.00%	1,239	1,239	16
17	V	26	Insurance/Prof/Liability		ARCRIC	100.00%	2,170	2,170	17
18	V	30	Depreciation		ARCRIC	100.00%	8,943	8,943	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			$			$ 12,874	$ * 12,874	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: 7/1/09 Ending: 6/30/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	None								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food and Beverage	The percent of budgeted	1,175,223	20 Programs	$ 196	$	305,541	$ 51	1
2	3	Housekeeping	Administrative costs are	1,175,223	20 Programs	13,373		305,541	3,477	2
3	5	Utilities	to be allocated based on	1,175,223	20 Programs	4,681		305,541	1,217	3
4	6	Maintanance	percentage of salary	1,175,223	20 Programs	14,439		305,541	3,754	4
5	19	Accountant/Consultant		1,175,223	20 Programs	44,932		305,541	11,682	5
6	19	Legal Fees		1,175,223	20 Programs	14,401		305,541	3,744	6
7	17	Administrative Salaries		1,175,223	20 Programs	583,788		305,541	151,776	7
8	20	Sub/Promotion/Printing		1,175,223	20 Programs	27,160		305,541	7,061	8
9	21	Office Expense		1,175,223	20 Programs	18,868		305,541	4,905	9
10	21	Telephone		1,175,223	20 Programs	3,886		305,541	1,010	10
11	22	Employee Benefits		1,175,223	20 Programs	156,172		305,541	40,602	11
12	10	Medical/Hygiene Supplies		1,175,223	20 Programs	3,063		305,541	796	12
13	23	Staff Training		1,175,223	20 Programs	278		305,541	72	13
14	24	Travel Seminar		1,175,223	20 Programs	2,006		305,541	522	14
15	25	Other Administration, Staff Transportation		1,175,223	20 Programs	4,764		305,541	1,239	15
16	26	Insurance/Prof/Liability		1,175,223	20 Programs	8,345		305,541	2,170	16
17	30	Depreciation		1,175,223	20 Programs	34,397		305,541	8,943	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 934,749	$		$ 243,021	25

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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.)**

Facility Name & ID Number Heritage Fifty-Three # 0024836 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2010 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:			
	2005		8
	2006		9
	2007		10
	2008		11
	2009		12

	FOR BHF USE ONLY		
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

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.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 7/1/09 Ending: 6/30/10

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? [X] (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? [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: None
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	DD Facility	196,020	1980	$ 98,594	1
2					2
3	TOTALS	196,020		$ 98,594	3

Facility Name & ID Number Heritage Fifty-Three # 24836 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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		6,962	13
14	Roof Repair, Asphalt, Remodeling			1993	15,650	497	31.5	497		9,822	14
15	Plumbing repairs, Sidewalk Ramp			1994	8,220	487	31.5	487		7,690	15
16	Roof and Hot Water System			1995	22,625	1,385	31.5	1,385		20,867	16
17	New Hot Water System			1996	50,449	1,149	31.5	1,149		16,660	17
18	Hot Water Continuation			1997	35,175	1,116	31.5	1,116		15,066	18
19	Hot Water Continuation			1997	4,202	210	31.5	210		2,730	19
20	Parking Lot Blacktop			1997	3,430	434	31.5	434		5,458	20
21	Shopper Driveway, Fire Alarm, Water Tank Tub			1998	35,520	1,032	31.5	1,032		11,868	21
22	Air/Fire Doors, Concrete Walks, Fuel Storage Tanks			1999	35,720	1,134	31.5	1,134		9,644	22
23	8 Power doors			2000	9,485	301	31.5	301		2,559	23
24	Automatic Doors			2000	9,989	317	31.5	317		3,012	24
25	Concrete Walks/5 Areas			2000	2,550	81	31.5	81		688	25
26	Electrical for Auto Doors			2000	1,414	45	31.5	45		427	26
27	Electrical for Auto Doors			2000	1,365	43	31.5	43		409	27
28	Install Whirlpool Tub			2000	7,320	232	31.5	232		2,204	28
29	Bedroom Remodel/Salary Expense			2000	1,169	37	31.5	37		352	29
30	Twin Furnaces			2000	5,520	175	31.5	175		1,663	30
31	Blacktop Parking Lot			2001	3,960	126	31.5	126		1,070	31
32	Air Conditioning Repairs			2001	1,411	45	31.5	45		382	32
33	Install 8 Furnace Units			2001	10,400	330	31.5	330		2,805	33
34	Install 2 Air Conditioning Units			2001	4,250	135	31.5	135		1,147	34
35	Install Air Conditioning Units in Kitchen			2001	1,750	56	31.5	56		476	35
36	Electrical for Home Theatre			2001	530	17	31.5	17		144	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 # 24836 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Kick Plates/Door Guards	2001	$ 900	$ 29	31.5	$ 29	$	$ 246	37
38	Concrete Sidewalk/Ramp	2002	3,525	112	31.5	112		840	38
39	Install 2 Air Conditioning Units	2002	2,125	67	31.5	67		503	39
40	Install 5 Fire Doors	2002	643	20	31.5	20		150	40
41	Motor for Air Conditioning Unit	2002	500	16	31.5	16		120	41
42	Re-tile Floors	2002	18,750	595	31.5	595		4,463	42
43	Install 4 Wood Fire Doors	2002	546	17	31.5	17		128	43
44	Install Accordian Door	2002	4,495	143	31.5	143		929	44
45	Install Kitchen Hood Exhaust Fan	2002	2,114	67	31.5	67		503	45
46	Install 8 Countertop	2002	1,140	36	31.5	36		270	46
47	Install Sensory Room/Electrical Work	2002	1,606	51	31.5	51		382	47
48	Grease Trap	2004	3,640	116	31.5	116		754	48
49	Repairs to Automatic Doors	2004	2,805	89	31.5	89		579	49
50	Sewer Repairs	2004	3,537	112	31.5	112		728	50
51	Re-Tile Kitchen Floor	2004	2,158	69	31.5	69		448	51
52	Sensory Room Electrical Work	2004	1,425	45	31.5	45		361	52
53	Install Air Conditioning Unit	2005	2,035	64	31.5	64		352	53
54	Update Fire System in Kitchen	2005	2,345	74	31.5	74		407	54
55	Install 29 Windows	2005	9,831	312	31.5	312		1,716	55
56	Install Whirlpool Tub	2005	2,898	92	31.5	92		506	56
57	Concrete Sidewalks	2005	3,650	116	31.5	116		638	57
58	Kitchen Cabinets	2005	4,705	149	31.5	149		820	58
59	Install Bathroom Tiles	2005	4,155	132	31.5	132		726	59
60	Install Lights/Electrical work	2005	10,120	321	31.5	321		1,766	60
61	Install Ceiling Tiles/Drywall	2005	21,746	690	31.5	690		3,795	61
62	Building Renovations/RV	2006	62,226	1,975	31.5	1,975		8,888	62
63	Building Renovations/BV	2006	5,703	181	31.5	181		815	63
64	Install Fence around 4 Building	2006	9,630	306	31.5	306		1,377	64
65	Concrete Patios/RV	2006	5,450	173	31.5	173		779	65
66	Concrete Patios/ER	2006	6,100	194	31.5	194		873	66
67	Commercial Garbage Disposal/Main Kitchen	2006	1,571	50	31.5	50		225	67
68	Replace Mixing Valves	2006	2,773	88	31.5	88		396	68
69	Remodel PT Room	2006	13,283	422	31.5	422		1,899	69
70	TOTAL (lines 4 thru 69)		$ 627,989	$ 21,167		$ 21,167	$	$ 291,727	70

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

Facility Name & ID Number Heritage Fifty-Three # 24836 Report Period Beginning: 7/1/2009 Ending: 6/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 627,989	$ 21,167		$ 21,167	$	$ 291,727	1
2	Generator Repairs	2007	1,244	39	31.5	39		137	2
3	Install New Bedroom and Bathroom Doors	2007	6,611	210	31.5	210		735	3
4	Retile Main Building Office/Hallways	2007	4,175	133	31.5	133		465	4
5	Sidewalk Repair between LW/RV	2007	1,200	38	31.5	38		133	5
6	New Fence around all buildings	2007	13,267	421	31.5	421		1,474	6
7	Install Fire Wall	2007	850	27	31.5	27		94	7
8	Build/Repair Walls	2007	1,400	44	31.5	44		154	8
9	Repair 3 doors BV	2007	680	22	31.5	22		77	9
10	Install Air Conditioning Unit in Kitchen	2007	2,900	92	31.5	92		322	10
11	Install 22 Windows LW	2007	8,360	265	31.5	265		928	11
12	Replace door and lock RV	2007	990	31	31.5	31		109	12
13	Clean Mixing Valves	2007	6,519	207	31.5	207		724	13
14	Install Kitchen Cabinets LW	2007	1,269	40	31.5	40		140	14
15	Repair Hot Water Heater RV	2007	1,578	50	31.5	50		175	15
16	Install 3 Soft Lite Windows	2007	1,259	40	31.5	40		140	16
17	Blacktop Front Circle Drive	2008	2,700	86	31.5	86		215	17
18	Repair Ducts in Main office building	2008	1,056	34	31.5	34		85	18
19	Install 16KW Generator	2008	13,200	419	31.5	419		1,048	19
20	Electrical Work/Main Office Building	2008	931	30	31.5	30		75	20
21	Wall/Plaster Repair Riverview	2008	1,125	36	31.5	36		90	21
22	Plumbing Work/Laundry facilities Riverview	2008	1,596	51	31.5	51		127	22
23	Clean Vents/Ducts Birchview	2008	965	31	31.5	31		77	23
24	Plumbing Work/Laundry & sink hookup Birchview	2008	1,023	32	31.5	32		80	24
25	Regrout Showers Birchview	2008	1,000	32	31.5	32		80	25
26	Install 4 Windows Birchview	2008	1,440	46	31.5	46		115	26
27	Install Closet Doors Birchview	2008	1,912	61	31.5	61		152	27
28	Install 4 Double Dressers Birchview	2008	3,680	117	31.5	117		292	28
29	Install Light Fixtures Birchview	2008	2,450	78	31.5	78		195	29
30	New Roof Birchview	2008	17,460	554	31.5	554		1,385	30
31	Wall/Plaster Repair Lakewood Remodel	2008	2,440	77	31.5	77		193	31
32	Wall Protectors and Installation Lakewood Remodel	2008	6,398	203	31.5	203		508	32
33	Install Bathroom Counterto /Towel bar Lakewood Remodel	2008	1,590	50	31.5	50		125	33
34	TOTAL (lines 1 thru 33)		$ 741,257	$ 24,763		$ 24,763	$	$ 302,376	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: 7/1/09 Ending: 6/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 741,257	$ 24,763		$ 24,763	$	$ 302,376	1
2	Tile/Grout work Kitchen Lakewood Remodel	2008	846	27	31.5	27		67	2
3	Regrout Showers Lakewood Remodel	2008	2,000	63	31.5	63		158	3
4	New Window Blinds Lakewood Remodel	2008	5,041	160	31.5	160		400	4
5	Painting Lakewood Remodel	2008	1,905	60	31.5	60		150	5
6	Install Built-In Bedroom Dressers Lakewood Remodel	2008	3,640	116	31.5	116		290	6
7	Install 17 Windows Lakewood Remodel	2008	6,120	194	31.5	194		485	7
8	Install 8 Bathroom Mirrors Lakewood Remodel	2008	982	31	31.5	31		78	8
9	New Tile Flooring Lakewood	2008	2,267	72	31.5	72		180	9
10	Install New Bathroom Sinks/Drains Lakewood Remodel	2008	6,386	203	31.5	203		507	10
11	Install 16 Closet Doors Lakewood Remodel	2008	7,648	242	31.5	242		605	11
12	Laminate 5 Med Closet Doors Lakewood Remodel	2008	1,090	35	31.5	35		87	12
13	Relaminate doors Lakewood Remodel	2008	4,270	136	31.5	136		340	13
14	Instsall New Doors/Frames Lakewood Remodel	2008	5,050	160	31.5	160		400	14
15	Electrical Work/Install Light Fixtures Lakewood Remodel	2008	15,892	505	31.5	505		1,262	15
16	Hardware supplies Lakewood Remodel	2008	1,933	61	31.5	61		153	16
17	Clean Vents/Ducts Lakewood	2008	965	31	31.5	31		77	17
18	Sidewalk Repair Lakewood	2008	7,050	224	31.5	224		560	18
19	New Roof on Riverview	2009	13,337	423	31.5	423		635	19
20	Install Handrails in Lakewood	2009	3,295	105	31.5	105		157	20
21	New Roof on Lakewood	2009	13,337	423	31.5	423		635	21
22	New Roof Main Bldg	2009	13,337	423	31.5	423		635	22
23	Concrete Work/Sidwalk Repair Main Building	2009	8,250	262	31.5	262		393	23
24	Underground Storage Tank	2009	1,134	36	31.5	36		54	24
25	Install New Ceiling Grid in Kitchen Main Building	2009	735	23	31.5	23		35	25
26	Install Additional Fire System Main Building	2009	5,384	171	31.5	171		256	26
27	New Shed	2009	1,506	48	31.5	48		72	27
28	New Tile Floor Main Building	2009	498	16	31.5	16		24	28
29	Repair Air Conditioning Units	2009	1,692	54	31.5	54		81	29
30	Repair Gutters Main Building	2009	1,150	37	31.5	37		55	30
31	Build Block Wall Main Building	2009	750	24	31.5	24		36	31
32	Install Circulating Pump Main Building	2009	1,466	47	31.5	47		70	32
33	Water Main Break Repairs Main Building	2009	11,806	375	31.5	375		562	33
34	TOTAL (lines 1 thru 33)		$ 892,019	$ 29,550		$ 29,550	$	$ 311,875	34

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

Facility Name & ID Number Heritage Fifty-Three # 24836 Report Period Beginning: 7/1/2009 Ending: 7/30/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 892,019	$ 29,550		$ 29,550	$	$ 311,875	1
2	Plumbing Repairs Main Building	2009	764	24	31.5	24		36	2
3	Install Generator/AMP Meter to Birchview	2009	11,000	349	31.5	349		524	3
4	Repairs to Fire Alarm Box in Birchview	2009	1,128	36	31.5	36		54	4
5	Install Vanities/Sinks in Bathrooms Birchview Remodel	2009	10,251	325	31.5	325		488	5
6	Built-In closet and Dressers Birchview Remodel	2009	18,516	588	31.5	588		882	6
7	Install Vertical Blinds Birchview Remodel	2009	3,390	108	31.5	108		162	7
8	Install New Lights Birchview Remodel	2009	9,907	315	31.5	315		472	8
9	Install Exterior Door Birchview Remodel	2009	1,286	41	31.5	41		61	9
10	Install/Re-laminate doors Birchview Remodel	2009	5,322	169	31.5	169		253	10
11	Install New Doors Locks Birchview Remodel	2009	1,349	43	31.5	43		64	11
12	Install 9 Mirrors Birchview Remodel	2009	1,140	36	31.5	36		54	12
13	Install Corner Boards/Cove Base Birchview Remodel	2009	4,353	138	31.5	138		207	13
14	Supplies for Birchview Remodel	2009	1,144	36	31.5	36		54	14
15	Concrete Work Birchview Remodel	2009	2,250	71	31.5	71		107	15
16	Kitchen Remodel/Install Backsplash Birchview Remodel	2009	5,909	188	31.5	188		282	16
17	Plumbing Work Birchview Remodel	2009	2,050	65	31.5	65		98	17
18	Baseboard Heat Birchview	2009	610	19	31.5	19		29	18
19	Electrical Work Birchview Remodel	2009	2,354	75	31.5	75		112	19
20	Concrete Pad for Generator H53	2010	1,700	27	31.5	27		27	20
21	Tile Showers area H53	2010	614	10	31.5	10		10	21
22	Generator for Birchview	2010	6,125	97	31.5	97		97	22
23	Electrical work for Generator Birchview H53	2010	3,000	48	31.5	48		48	23
24	Siding Lakewood	2010	17,500	278	31.5	278		278	24
25	Compressors for Air Conditioning Units at Lakewood	2010	3,844	61	31.5	61		61	25
26	Concrete Sidewalks/Drive Apron at H53	2010	5,700	90	31.5	90		90	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,013,225	$ 32,787		$ 32,787	$	$ 316,425	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: 7/1/09 Ending: 6/30/10

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	$ 586,857	$ 73,320	$ 73,320	$	10	$ 449,650	71
72	Current Year Purchases	6,329	633	633		10	633	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 593,186	$ 73,953	$ 73,953	$		$ 450,283	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2008 Chevy Uplander	2008	$ 36,000	$ 12,000	$ 12,000	$	5	$ 12,000	76
77										77
78										78
79										79
80	TOTALS			$ 36,000	$ 12,000	$ 12,000	$		$ 12,000	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)	$ 1,741,005	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 118,740	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 118,740	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)	$ 778,708	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

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: *

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	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 60

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		175	150		325
3	Classroom Wages	(a)	2,975	3,192		6,167
4	Clinical Wages	(b)	3,969	4,254		8,223
5	In-House Trainer Wages	(c)	9,408	10,080		19,488
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$ 16,527	$ 17,676	$	$ 34,203
10	SUM OF line 9, col. 1 and 2	(e)	$ 34,203			

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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	
TOTAL TRAINED	13

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

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

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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 996,370	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	367,332		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,085		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,365,787	$	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	1,013,225		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	629,186		16
17	Accumulated Depreciation (book methods)	(778,708)		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)**	$ 962,297	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,328,084	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 82,990	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	305,226		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 388,216	$	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)**	$ 388,216	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,939,868	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,328,084	$	48

*(See instructions.)

Facility Name & ID Number Heritage Fifty-Three **#** 0024836 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,081,256	1
2	Restatements (describe):		2
3	**Fixed Asset reclassification**	(364,713)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,716,543	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	223,325	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)**	$ 223,325	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,939,868	24 *

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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,925,825	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,925,825	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	519	9
10	Other Government Grants	6,519	10
11	CNA Training Reimbursements	11,160	11
12	Gift and Coffee Shop	2,172	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	4,368	21
22	Laundry	10,833	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 35,571	23
	D. Non-Operating Revenue		
24	Contributions	15,170	24
25	Interest and Other Investment Income***	2,753	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,923	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Day Training Revenue	34,684	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 34,684	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,014,003	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	561,790	31
32	Health Care	1,461,181	32
33	General Administration	498,974	33
	B. Capital Expense		
34	Ownership	109,797	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	158,936	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,790,678	40
41	**Income before Income Taxes (line 30 minus line 40)****	223,325	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 223,325	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: 7/1/09 Ending: 6/30/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,824	1,961	$ 48,130	$ 24.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	168	181	3,049	16.85	3
4	Licensed Practical Nurses	12,447	13,384	229,847	17.17	4
5	CNAs & Orderlies					5
6	CNA Trainees	1,182	1,271	14,390	11.32	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,905	2,048	29,546	14.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,607	13,556	123,494	9.11	15
16	Dishwashers					16
17	Maintenance Workers	1,972	2,121	19,980	9.42	17
18	Housekeepers	4,758	5,116	48,854	9.55	18
19	Laundry					19
20	Administrator	2,225	2,392	60,643	25.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	411	442	5,853	13.24	23
24	Clerical	444	478	6,383	13.35	24
25	Vocational Instruction					25
26	Academic Instruction	421	958	19,488	20.34	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,803	6,240	91,371	14.64	28
29	Resident Services Coordinator	7,896	8,490	127,106	14.97	29
30	Habilitation Aides (DD Homes)	73,468	78,998	894,258	11.32	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,531	137,636	$ 1,722,392 *	$ 12.51	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	115	$ 4,506	L1C3	35
36	Medical Director				36
37	Medical Records Consultant	annual	4,725	L9C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	479	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)	126	$ 9,710		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Smith	Adiminstrator		$ 50,540
Julie Williams	Assoc. Ex. Dir.		10,103
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,643

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,051
Unemployment Compensation Insurance	13,382
FICA Taxes	139,017
Employee Health Insurance	67,661
Employee Meals	20,650
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense Employer Paid	92,267
Disability Insurance	318
Group Term Insurance	2,493
Admin Fringe Benefits from	
schedule VIII line 11 c9	40,602
Immunization Costs	445
TOTAL (agree to Schedule V, line 22, col.8)	$ 436,886

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,300
Advertising: Employee Recruitment	6,258
Health Care Worker Background Check	
(Indicate # of checks performed 60)	900
Patient Background Checks	
Arc of IL and US Dues	3,600
Staff Awards and Promotions, Advocacy	
Subscriptions	30
Direct Deposit Fees	780
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,868

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,298
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,298

**See instructions.

Facility Name & ID Number Heritage Fifty-Three # 0024836 Report Period Beginning: 7/1/09 Ending: 6/30/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heritage Fifty-Three **#** 0024836 **Report Period Beginning:** 7/1/09 **Ending:** 6/30/10

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. $ **158,936**
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. $ **20,650** 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.