		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: 0018176

Facility Name: Heritage Square

Address: 620 North Ottawa Avenue (Number) Dixon (City) 61021 (Zip Code)

County: Lee

Telephone Number: 815-288-251 **Fax #** 815-288-6821

HFS ID Number:

Date of Initial License for Current Owners: 11/08/1974

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Julia O'Farrell, Bookkeeper **Telephone Number:** 815-288-2251
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 01/01/10 to 12/31/10 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) Bonnie K. O'Connell
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) N/A
(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 Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	27	Skilled (SNF)	27	9,855	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	49	Sheltered Care (SC)	49	17,885	5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	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	1,144	8,496		9,640	10
11	ICF/DD					11
12	SC		16,286		16,286	12
13	DD 16 OR LESS					13
14	TOTALS	1,144	24,782		25,926	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.46%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
0

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 11/07/1974

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

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 _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	272,089	22,974	2,049	297,112		297,112	(249)	296,863			1
2	Food Purchase		266,396		266,396		266,396	(11,623)	254,773			2
3	Housekeeping	126,897	17,312	412	144,621		144,621		144,621			3
4	Laundry	33,501	13,659		47,160		47,160		47,160			4
5	Heat and Other Utilities			130,518	130,518		130,518	(12,523)	117,995			5
6	Maintenance	103,941	39,298	240	143,479		143,479	(4,659)	138,820			6
7	Other (specify):* Waste Removal			3,375	3,375		3,375		3,375			7
8	TOTAL General Services	536,428	359,639	136,594	1,032,661		1,032,661	(29,054)	1,003,607			8
	B. Health Care and Programs											
9	Medical Director				1,875		1,875		1,875			9
10	Nursing and Medical Records	973,598	43,968	4,535	1,022,101		1,022,101	(3,017)	1,019,084			10
10a	Therapy	52,263		1,964	54,227		54,227		54,227			10a
11	Activities	93,066	1,040	3,225	97,331		97,331		97,331			11
12	Social Services	54,144	1,116	175	55,435		55,435		55,435			12
13	CNA Training											13
14	Program Transportation		2,437		2,437		2,437		2,437			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,173,071	48,561	9,899	1,233,406		1,233,406	(3,017)	1,230,389			16
	C. General Administration											
17	Administrative	90,000			90,000		90,000		90,000			17
18	Directors Fees											18
19	Professional Services			18,101	18,101		18,101	(621)	17,480			19
20	Dues, Fees, Subscriptions & Promotions			37,828	37,828		37,828	(28,642)	9,186			20
21	Clerical & General Office Expenses	132,030	15,678	18,749	166,457		166,457	(643)	165,814			21
22	Employee Benefits & Payroll Taxes			413,232	413,232		413,232		413,232			22
23	Inservice Training & Education			250	250		250		250			23
24	Travel and Seminar			5,010	5,010		5,010	(3,288)	1,722			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			47,887	47,887		47,887		47,887			26
27	Other (specify):*											27
28	TOTAL General Administration	222,030	15,678	541,057	778,765		778,765	(33,194)	745,571			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,931,529	423,878	687,550	3,044,832		3,044,832	(65,265)	2,979,567			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 Square #0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			143,117	143,117		143,117		143,117			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(312,172)	(312,172)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			143,117	143,117		143,117	(312,172)	(169,055)			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			14,783	14,783		14,783		14,783			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			14,783	14,783		14,783		14,783			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,931,529	423,878	845,450	3,202,732		3,202,732	(377,437)	2,825,295			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 Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	11,623	V-A-2-7		4
5	Telephone, TV & Radio in Resident Rooms	12,523	V-A-5-7		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	312,172	D-37-7		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	643	V-C-21-7		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	621	V-C-30-7		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	22,640	V-C-31-7		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	6,002	V-C-31-7		28
29	Other-Attach Schedule QIS Software Maint	3,017	V-B-10-7		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 369,241		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 369,241		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heritage Square

ID# 0018176

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Service Contract-MDS Software	$ 249	V-A-1-7	1
2	Ground Maintenance	2,278	V-A-6-7	2
3	Repairs to Furniture	53	V-A-6-7	3
4	Other Gen. Maint. (Office Supp.)	294	V-A-6-7	4
5	Non-Allowable Travel/Seminars	3,288	V-C-24-7	5
6	Gas, Oil & Grease	2,034	V-A-6-7	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**	8,196		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Square **#** 0018176 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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	(249)	0	0	0	0	0	0	0	0	0	0	(249)	1
2	Food Purchase	(11,623)	0	0	0	0	0	0	0	0	0	0	(11,623)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(12,523)	0	0	0	0	0	0	0	0	0	0	(12,523)	5
6	Maintenance	(4,659)	0	0	0	0	0	0	0	0	0	0	(4,659)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(29,054)	0	0	0	0	0	0	0	0	0	0	(29,054)	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	(3,017)	0	0	0	0	0	0	0	0	0	0	(3,017)	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**	(3,017)	0	0	0	0	0	0	0	0	0	0	(3,017)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(621)	0	0	0	0	0	0	0	0	0	0	(621)	19
20	Fees, Subscriptions & Promotions	(28,642)	0	0	0	0	0	0	0	0	0	0	(28,642)	20
21	Clerical & General Office Expenses	(643)	0	0	0	0	0	0	0	0	0	0	(643)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,288)	0	0	0	0	0	0	0	0	0	0	(3,288)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(33,194)	0	0	0	0	0	0	0	0	0	0	(33,194)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(65,265)	0	0	0	0	0	0	0	0	0	0	(65,265)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Square # 0018176 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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	143,117	0	0	0	0	0	0	0	0	0	0	143,117	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(312,172)	0	0	0	0	0	0	0	0	0	0	(312,172)	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**	(169,055)	0	0	0	0	0	0	0	0	0	0	(169,055)	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)**	(234,320)	0	0	0	0	0	0	0	0	0	0	(234,320)	45

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 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 Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [ ] NO [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Square COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0018176

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 Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,354 B. General Construction Type: Exterior Brick Frame Steel Griders Metal Number of Stories 2

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).

1. Warner Campus - 2 Free Standing Buildings which equals 4 units.
2. Each of the above 4 units equal 1160 Sq.Ft. each, plus garage.
(Above information taken from architect prints.)

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: 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	Home for Aged	97,046	1963	$ 42,888	1
2				31,315	2
3	TOTALS	97,046		$ 74,203	3

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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			1974	1974	$ 1,532,081	$ 38,302	40	$ 38,302	$	$ 1,388,545	4
5			1993	1993	1,100,199	27,505	40	27,505		481,337	5
6											6
7											7
8											8
	Improvement Type**										
9	Outdoor Lights			1977	696		20			696	9
10	Patio Cover			1980	3,729		10			3,729	10
11	Storeroom Sprinkler			1981	1,309		20			1,309	11
12	P.T. & Rehab.Rm			1985	18,461		18			18,461	12
13	L.L.Actv.(ReassignedB.SP.)			1985	3,229		19			3,229	13
14	Soc.Service Office			1988	1,319		20			1,319	14
15	Roof (HCCwing)			1988	5,940		15			5,940	15
16	Parking Lot			1989	11,398		20			11,398	16
17	Gutter & Downspouts (S.Wing)			1991	4,500		15			4,500	17
18	Plumbing Replacement			1991	2,099	99	20	99		1,999	18
19	Storage Shed			1991	1,189	57	20	57		1,131	19
20	Fire Alarm Improvement			1991	1,630	78	20	78		1,555	20
21	Intercom Improvement			1992	508		15			508	21
22	Fire Protection Beams			1993	1,380		10			1,380	22
23	Concrete Walk & Driveway			1993	6,008		15			6,008	23
24	Landscaping (New Wing)			1993	7,749		10			7,749	24
25	Resurface Parking Lot			1993	17,716		15			17,716	25
26	Gutter & Downspouts (N. Wing)			1993	3,600		15			3,600	26
27	Heating (HCC Floor)			1994	3,966		10			3,966	27
28	Elevator Safety Shield			1994	1,250		10			1,250	28
29	Concrete Walk & Bench Pad			1994	1,225	58	20	58		1,013	29
30	Painting Facia of Building			1994	1,955		5			1,955	30
31	Life Safety Door Closer (replace)			1995	4,432	276	15	276		4,396	31
32	Patio Sidewalk (Replace)			1995	6,507	309	20	309		4,895	32
33	Soffit Repair (Vinyl)			1995	4,100	195	20	195		3,086	33
34	Attic Ventilation (S.Wing in SC)			1996	11,600	551	20	551		8,149	34
35	Exterior Walks & Drive			1996	3,809	181	20	181		2,675	35
36	Cont'd on Page 12A										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 Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	
37	N.E. Outdoor Storage Shed	1996	$ 707	$ 33	20	$ 33	$	$ 495	37
38	Lighting Replacement(Energy Efficient)	1997	13,031	811	15	811		11,207	38
39	Radiant Heat Panels (S.C.)	1998	19,894		10			19,894	39
40	8 Attic Exhaust Fans	1998	6,356	302	20	302		3,777	40
41	Kitchen Fire Systems	1998	898	43	20	43		523	41
42	Painting	1999	11,227		5			11,227	42
43	Deposit Bldg.Extens.	2000	2,346						43
44	GFI Electrical Upgrads	2000	4,800	228	20	228		2,312	44
45	Paint Halls & Doors	2001	5,970		5			5,970	45
46	New South Roof	2002	171,935	5,731	30	5,731		47,282	46
47	New North Roof	2003	140,137	4,671	30	4,671		33,477	47
48	Replacement of Clay & Tile & Pvc	2005	1,153	39	30	39		215	48
49	Repair & Replace.No.Driveway	2005	9,330	622	15	622		3,162	49
50	Bathroom Tile	2005	1,500	75	20	75		438	50
51	Repair & Waterproof Balcony	2005	6,500	325	20	325		1,760	51
52	Exit/Cylinder Change Room Doors	2005	4,426	222	20	222		1,199	52
53	Prime & Paint Handrail on Bldg.	2005	3,360	336	10	336		1,764	53
54	New Locks for half of Res.rooms	2006	2,897	145	20	145		664	54
55	Carpet for offices and entrance	2006	7,307	1,461	5	1,461		6,698	55
56	Concrete Work	2006	2,595	173	15	173		750	56
57	Automatic door for courtyard	2006	2,665	133	20	133		555	57
58	Asphalt half cirlce driveway	2006	2,300	154	15	154		652	58
59	Carpet for Residents/Hallways	2007	3,014	301	10	301		1,080	59
60	Metal Wall	2007	9,523	476	20	476		1,746	60
61	Commodes	2007	1,366	137	10	137		501	61
62	Flowers-Landscaping	2007	250	35	3	35		250	62
63	Fire Alarm Control Panel \	2007	8,000	800	10	800		2,867	63
64	Smoke Detectors/horns/strobes	2007	8,763	876	10	876		3,067	64
65	Concrete Patio	2007	5,860	293	20	293		1,026	65
66	Wall Station Dukane 4A1225	2007	723	144	5	144		494	66
67	Floor Pedal Sink	2007	380	38	10	38		130	67
68	Actuator Lift	2007	1,072	107	10	107		357	68
69	Cont'd on Page 12B								69
70	TOTAL (lines 4 thru 69)		$ 3,223,869	$ 86,322		$ 86,322	$	$ 2,159,033	70

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 12A, Carried Forward		$ 3,223,869	$ 86,322		$ 86,322	$	$ 2,159,033	1
2	IDPH-Fire Imprv.Caulking/FireAlarmPanel	2007	8,755	437	20	437		1,313	2
3	IDPH-Luse Thermal/Doors,Frames,Hardware	2008	19,090	954	20	954		2,863	3
4	IDPH-RollingFireDoor,LuseThermal	2008	11,580	579	20	579		1,689	4
5	IDPH-RollingFireDoor,LuseThermal	2008	10,247	512	20	512		1,366	5
6	Door Locks-Resident Rooms	2008	2,786	140	20	140		395	6
7	Ceramic Tile for 2nd Flr Dining	2008	1,064	107	10	107		213	7
8	New Carpet for Unit A	2008	806	81	10	81		175	8
9	New Carpet	2008	1,511	151	10	151		415	9
10	Cove Base Installation-Carpet/Gluedown	2008	806	80	10	80		208	10
11	ACS Processor (Main Phone System)	2008	1,200	120	10	120		290	11
12	New Cabinets-HCC Dining Area	2008	563	56	10	56		131	12
13	Fire Dampers in Kitchen	2008	1,600	80	20	80		207	13
14	Smoke Dect.,Alarms to Fire Panel	2008	1,300	130	10	130		347	14
15	Frames for Doors	2008	2,846	285	10	285		593	15
16	Doors & Drywall	2008	9,309	466	20	466		970	16
17	Sliding Front Door	2008	5,940	297	20	297		693	17
18	Smoke Dect.,Alarms to Fire Panel	2008	1,580	158	10	158		435	18
19	Fire Alarm Phase II	2008	3,200	320	10	320		640	19
20	New Roof	2008	106,223	3,541	30	3,541		8,262	20
21	Raining-Fabricate/Install on Stairs	2009	3,000	300	10	300		575	21
22	Door-Bookkeepers Office	2009	538	27	20	27		52	22
23	Fire System Upgrade-Phase III Part I	2009	4,553	456	10	456		873	23
24	Fire System Upgrade-Phase III Part II	2009	7,320	732	10	732		1,342	24
25	Stainless Steel Cabinets/Counter-HCC	2009	4,506	451	10	451		789	25
26	Metal Door/Kitchen	2009	1,150	115	10	115		173	26
27	Asphalt/Prime-North Parking Lot	2009	11,430	762	15	762		1,143	27
28	Kitchen Floor Renov.	2009	21,628	1,082	20	1,082		1,442	28
29	Railings-Courtyard	2009	1,920	192	10	192		256	29
30	Refrigerator Door	2009	3,500	350	10	350		467	30
31	Cabinets-HCC Dining Room	2009	648	65	10	65		70	31
32	Door-Life Safety Code	2009	4,680	234	20	234		234	32
33	Counter Tops for HCC	2010	394	52	7	52		52	33
34	TOTAL (lines 1 thru 33)		$ 3,479,542	$ 99,634		$ 99,634	$	$ 2,187,706	34

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		$ 3,479,542	$ 99,634		$ 99,634	$	$ 2,187,706	1
2	Sidewalk-McKinney to Morgan on Brinton	2010	3,400	94	15	94		94	2
3	Carpet Room 37 & 38	2010	1,208	101	5	101		101	3
4	Carpet-SC	2010	631	42	5	42		42	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	TOTAL (lines 1 thru 33)		$ 3,484,781	$ 99,871		$ 99,871	$	$ 2,187,943	34

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 743,662	$ 41,626	$ 41,626	$		$ 372,880	71
72	Current Year Purchases	29,584	1,620	1,620			850	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 773,246	$ 43,246	$ 43,246	$		$ 373,730	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 Transport	2001 Grand Marquis Mercury	2005	$ 13,011	$	$	$	4	$ 13,011	76
77										77
78										78
79										79
80	TOTALS			$ 13,011	$	$	$		$ 13,011	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)	$ 4,345,241	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,117	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,117	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)	$ 2,574,684	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 Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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?
   - [ ] YES
   - [X] 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 [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(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.)

	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 Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/10 (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	$ 148,328	$	1
2	Cash-Patient Deposits	6,665		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at cost)	32,998		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,335		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest	24,956		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 217,282	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	35,000		11
12	Long-Term Investments	2,684,941		12
13	Land	74,203		13
14	Buildings, at Historical Cost	3,484,532		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	771,449		16
17	Accumulated Depreciation (book methods)	(2,747,270)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,698,397		21
22	Other Long-Term Assets (spe InPrepetual Trust	5,290,513		22
23	Other(specify): R.L. Warner Campus	188,305		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,480,070	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,697,352	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 42,664	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,989		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)**	$ 156,653	$	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)**	$ 156,653	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,540,699	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,697,352	$	48

*(See instructions.)

Facility Name & ID Number Heritage Square **#** 0018176 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,021,873	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,021,873	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	518,826	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)**	$ 518,826	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)**	$ 11,540,699	24 *

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 2,861,413	1
2	Discounts and Allowances for all Levels	(106,899)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,754,514	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,987	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 15,987	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	162	12
13	Barber and Beauty Care	2,025	13
14	Non-Patient Meals	7,919	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	32,021	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 42,127	23
	D. Non-Operating Revenue		
24	Contributions	6,275	24
25	Interest and Other Investment Income***	312,172	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 318,447	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Beneficial Trust Income(loss)on fair value	283,950	28
28a	Gain on Net Assets	306,533	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 590,483	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,721,558	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,032,661	31
32	Health Care	1,233,406	32
33	General Administration	778,765	33
	B. Capital Expense		
34	Ownership	143,117	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	14,783	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,202,732	40
41	**Income before Income Taxes (line 30 minus line 40)****	518,826	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 518,826	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 Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	1,529	1,600	$ 41,107	$ 25.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,181	11,674	291,035	24.93	3
4	Licensed Practical Nurses	10,380	11,086	250,061	22.56	4
5	CNAs & Orderlies	36,097	37,141	387,898	10.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,799	4,075	52,263	12.83	8
9	Activity Director	2,004	2,127	40,460	19.02	9
10	Activity Assistants	4,823	5,174	52,606	10.17	10
11	Social Service Workers	3,971	4,056	54,144	13.35	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,026	36,558	18.04	13
14	Head Cook	7,495	7,731	54,651	7.07	14
15	Cook Helpers/Assistants	17,712	18,343	163,309	8.90	15
16	Dishwashers	1,838	1,974	17,571	8.90	16
17	Maintenance Workers	7,159	7,356	103,941	14.13	17
18	Housekeepers	12,285	13,002	126,897	9.76	18
19	Laundry	3,565	3,805	33,501	8.80	19
20	Administrator	2,240	2,489	90,000	36.16	20
21	Assistant Administrator					21
22	Other Administrative	2,448	2,288	50,000	21.85	22
23	Office Manager	1,937	2,089	34,500	16.52	23
24	Clerical	3,803	3,914	34,676	8.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	139	139	1,740	12.52	31
32	Other Health C: MDS Coordinator	78	78	1,757	22.53	32
33	Other(specify) Driver	1,432	1,552	12,854	8.28	33
34	TOTAL (lines 1 - 33)	137,755	143,719	$ 1,931,529 *	$ 13.44	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	Contract	$ 1,800	V-A-1-3	35
36	Medical Director	Contract	1,875	V-B-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	33	1,493	V-B-10-3	39
40	Physical Therapy Consultant	Contract	1,617	V-B-10a-3	40
41	Occupational Therapy Consultant	Contract	347	V-B-10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	3	225	V-B-11-3	44
45	Social Service Consultant	2	150	V-B-12-3	45
46	Other(specify) Chaplain	Contract	2,175	V-B-11-3	46
47	QA Physicians	1	25	V-B-10-3	47
48	Sunday Clergy	33	825	V-B-11-3	48
49	TOTAL (lines 35 - 48)	72	$ 10,532		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 Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonnie K. O'Connell	Administrator	0	$ 90,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 90,000

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
Clifton&Gunderson	Audit	$ 13,950
Clifton&Gunderson	DataProcess	1,305
Ward, Murray, Pace	Legal	2,163
EhrmannGehlbachLee	Legal	683
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 18,101

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,835
Unemployment Compensation Insurance	6,696
FICA Taxes	147,762
Employee Health Insurance	189,369
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,570
TOTAL (agree to Schedule V, line 22, col.8)	$ 413,232

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	$ 1,990
Advertising: Employee Recruitment	1,676
Health Care Worker Background Check	1,440
(Indicate # of checks performed 48)	
Patient Background Checks 13	130
LSN/AAHSA	3,590
ILActv./Creative/Actv.Dues	150
CLIA Labortary User Fee	150
Creative Forcasting	60
Non-Allowable Total	28,642
Less: Public Relations Expense	(179)
Non-allowable advertising	(22,461)
Yellow page advertising	(6,002)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,186

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
	248
	172
In-State Travel	
Chicago	248
Lisle	200
Seminar Expense	
LSN/AAHASHA	565
MDS/3.0	289
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,722

**See instructions.

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/10 Ending: 12/31/10

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													
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9													
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11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $3590**

(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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,869** Line **B-10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ 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. $ **14,783**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **11,623**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **90%**
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? **N/A**
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. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Clifton Gunderson LLC**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.