		FOR BHF USE					

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 815-288-2251 **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 01/01/12 to 12/31/12 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: 01/01/12 Ending: 12/31/12

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	9,882	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	49	Sheltered Care (SC)	49	17,934	5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	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	1,830	7,565		9,395	10
11	ICF/DD					11
12	SC		16,071		16,071	12
13	DD 16 OR LESS					13
14	TOTALS	1,830	23,636		25,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.55%

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: 12/31/12 Fiscal Year: 12/31/12

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

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

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	274,747	25,121	1,825	301,693		301,693		301,693			1
2	Food Purchase		285,807		285,807		285,807	(7,898)	277,909			2
3	Housekeeping	121,901	25,415	99	147,415		147,415		147,415			3
4	Laundry	42,331	10,089		52,420		52,420		52,420			4
5	Heat and Other Utilities			116,127	116,127		116,127	(16,622)	99,505			5
6	Maintenance	105,410	66,780	2,213	174,403		174,403	(4,684)	169,719			6
7	Other (specify):* Waste Removal			3,951	3,951		3,951		3,951			7
8	TOTAL General Services	544,389	413,212	124,215	1,081,816		1,081,816	(29,204)	1,052,612			8
	B. Health Care and Programs											
9	Medical Director			1,850	1,850		1,850		1,850			9
10	Nursing and Medical Records	1,033,111	56,595	5,588	1,095,294		1,095,294	(3,073)	1,092,221			10
10a	Therapy	56,175		4,473	60,648		60,648		60,648			10a
11	Activities	95,555	1,431	3,283	100,269		100,269		100,269			11
12	Social Services	56,986	1,332	473	58,791		58,791		58,791			12
13	CNA Training											13
14	Program Transportation		2,456		2,456		2,456	(351)	2,105			14
15	Other (specify):* Nurse P.T. Training			800	800		800		800			15
16	TOTAL Health Care and Programs	1,241,827	61,814	16,467	1,320,108		1,320,108	(3,424)	1,316,684			16
	C. General Administration											
17	Administrative	95,000			95,000		95,000		95,000			17
18	Directors Fees											18
19	Professional Services			16,376	16,376		16,376	(998)	15,378			19
20	Dues, Fees, Subscriptions & Promotions			43,551	43,551		43,551	(31,817)	11,734			20
21	Clerical & General Office Expenses	136,031	9,411	13,385	158,827		158,827	(3,803)	155,024			21
22	Employee Benefits & Payroll Taxes			414,565	414,565		414,565		414,565			22
23	Inservice Training & Education			45	45		45		45			23
24	Travel and Seminar			1,734	1,734		1,734		1,734			24
25	Other Admin. Staff Transportation			163	163		163		163			25
26	Insurance-Prop.Liab.Malpractice			36,869	36,869		36,869		36,869			26
27	Other (specify):*											27
28	TOTAL General Administration	231,031	9,411	526,688	767,130		767,130	(36,618)	730,512			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,017,247	484,437	667,370	3,169,054		3,169,054	(69,246)	3,099,808			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:** 01/01/12 **Ending:** 12/31/12

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			150,932	150,932		150,932		150,932			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(642,287)	(642,287)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			150,932	150,932		150,932	(642,287)	(491,355)			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			115,821	115,821		115,821		115,821			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			115,821	115,821		115,821		115,821			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,017,247	484,437	934,123	3,435,807		3,435,807	(711,533)	2,724,274			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: 01/01/12 Ending: 12/31/12

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	7,898	V-A-2-7		4
5	Telephone, TV & Radio in Resident Rooms	16,622	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	642,287	V-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	149	V-C-20-7		17
18	Fines and Penalties	2,150	V-C-20-7		18
19	Entertainment				19
20	Contributions	573	V-C-21-7		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	30,476	V-C-20-7		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	5,027	V-C-20-7		28
29	Other-Attach Schedule See 5A	6,337			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 711,519		$	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))**	$ 711,519		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: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Employee Appr. Day through out the year	$ 1,653	V-C-21-7	1
2	Grounds Maintenance	4,684	V-A-6-7	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**	6,337		49

STATE OF ILLINOIS

Summary A

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

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	(7,898)	0	0	0	0	0	0	0	0	0	0	(7,898)	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	(16,622)	0	0	0	0	0	0	0	0	0	0	(16,622)	5
6	Maintenance	(4,684)	0	0	0	0	0	0	0	0	0	0	(4,684)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(29,204)	0	0	0	0	0	0	0	0	0	0	(29,204)	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	(3,073)	0	0	0	0	0	0	0	0	0	0	(3,073)	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	(351)	0	0	0	0	0	0	0	0	0	0	(351)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,424)	0	0	0	0	0	0	0	0	0	0	(3,424)	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	(998)	0	0	0	0	0	0	0	0	0	0	(998)	19
20	Fees, Subscriptions & Promotions	(31,817)	0	0	0	0	0	0	0	0	0	0	(31,817)	20
21	Clerical & General Office Expenses	(3,803)	0	0	0	0	0	0	0	0	0	0	(3,803)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	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**	(36,618)	0	0	0	0	0	0	0	0	0	0	(36,618)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(69,246)	0	0	0	0	0	0	0	0	0	0	(69,246)	29

STATE OF ILLINOIS

Summary B

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

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	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(642,287)	0	0	0	0	0	0	0	0	0	0	(642,287)	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**	(642,287)	0	0	0	0	0	0	0	0	0	0	(642,287)	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)**	(711,533)	0	0	0	0	0	0	0	0	0	0	(711,533)	45

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

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE PAGE - SUPPLEMENTAL						

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

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

1 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: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	William Reigle-President	BOD						2
3	Patrick Jones-Vice-President	BOD						3
4	Charles Beckman-Secretary	BOD						4
5	Dr.Richard Collins-Treasurer	BOD						5
6	James Sarver	BOD						6
7	Dr.Tim Appenheimer	BOD						7
8	Patti Balayti	BOD						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

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

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									$		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: 01/01/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
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: 01/01/12 Ending: 12/31/12

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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 7 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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$	$ 1,465,149	4
5			1993	1993	1,100,199	27,505	40	27,505		536,347	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			1985	1,319		20			1,319	14
15	Roof (HCCwing)			1988	5,940		15			5,940	15
16	Parking Lot			1988	11,398		20			11,398	16
17	Gutter & Downspouts (S.Wing)			1991	4,500		15			4,500	17
18	Drain Line Trough			1991	2,099		20			2,099	18
19	Storage Shed			1991	1,189	2	20	2		1,189	19
20	Fire Alarm Wiring			1991	1,630		20			1,630	20
21	Intercom Improvement			1992	508		15			508	21
22	First Protection Beams			1992	1,380		10			1,380	22
23	Conrete 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)			1993	3,966		10			3,966	27
28	Elevator Safety Shield			1994	1,250		20			1,250	28
29	Concrete Walk & Bench Pad			1994	1,225	58	5	58		1,129	29
30	Painting Facia of Building			1994	1,955		15			1,955	30
31	Life Safety Door Closer (replace)			1995	4,432		20			4,432	31
32	Patio Sidewalk (Replace)			1995	6,507	309	20	309		5,513	32
33	Soffit Repair (Vinyl)			1995	4,100	194	20	194		3,475	33
34	Attic Ventilation (S.Wing in SC)			1996	11,600	551	20	551		9,251	34
35	Exterior Walks & Drive			1996	3,809	180	20	180		3,036	35
36											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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 34	20	$ 34	$	$ 563	37
38	Lighting Replacement(Engergy Effcient)	1997	13,031	811	15	811		12,829	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		4,381	40
41	Kitchen Fire Systems	1998	898	42	20	42		608	41
42	Painting	1999	11,227		5			11,227	42
43	Deposit Bldg.Extens.	2000	2,346						43
44	GFI Electric Upgrades	2000	4,800	228	20	228		2,768	44
45	Paint Halls & Doors	2001	5,970		5			5,970	45
46	New South Roof	2002	171,935	5,731	30	5,731		58,744	46
47	New North Roof	2003	140,137	4,672	30	4,672		42,820	47
48	Bathroom Tile	2005	1,500	75	30	75		588	48
49	Replacement of Clay & Tile & Pvc	2005	1,153	38	30	38		291	49
50	Repair & Waterproof Balcony	2005	6,500	325	20	325		2,410	50
51	Exit/Cylinder Change Room Doors	2005	4,426	221	20	221		1,641	51
52	Prime & Paint Handrail on Bldg.	2005	3,360	336	10	336		2,436	52
53	Repair & Blacktop North Driveway	2005	9,330	622	15	622		4,406	53
54	New Locks for half of Res.rooms	2006	2,897	145	20	145		954	54
55	Carpet for offices and entrance	2006	7,307		5			7,307	55
56	Concrete Work	2006	2,595	173	15	173		1,096	56
57	Automatic door for courtyard	2006	2,665	134	20	134		822	57
58	Asphalt half circle driveway	2006	2,300	153	15	153		958	58
59	Carpet for Residents/Hallways	2007	3,014	301	10	301		1,683	59
60	Metal Wall	2007	9,523	476	20	476		2,698	60
61	Commodes	2007	1,366	137	10	137		774	61
62	Fire Alarm Control Panel	2007	8,000	800	10	800		4,467	62
63	Smoke Dectectors/horns/strobes	2007	8,763	877	10	877		4,820	63
64	Conrete Patio	2007	5,860	293	20	293		1,612	64
65	Wall Station Dukane 4A1225	2007	723	84	5	84		723	65
66	Floor Pedal Sink	2007	380	38	10	38		206	66
67	Actuator Lift	2007	1,072	107	10	107		572	67
68	IDPH Fire Improv/Caulking fire alarm panel	2007	8,755	438	20	438		2,189	68
69	Cont'd on Page 12B								69
70	TOTAL (lines 4 thru 69)		$ 3,232,374	$ 84,694		$ 84,694	$	$ 2,330,420	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 3,232,374	$ 84,694		$ 84,694	$	$ 2,330,420	1
2	IDPH-Luse Thermal/Doors,Frames,Hardware	2008	19,090	954	20	954		4,772	2
3	IDPH-RollingFireDoor,LuseThermal	2008	11,580	579	20	579		2,847	3
4	IDPH-RollingFireDoor,LuseThermal	2008	10,247	512	20	512		2,391	4
5	Door Locks-Resident Rooms	2008	2,786	139	20	139		673	5
6	Ceramic Tile for 2nd Flr Dining	2008	1,064	107	10	107		426	6
7	New Carpet for Unit A	2008	806	81	10	81		336	7
8	New Carpet	2008	1,511	151	10	151		718	8
9	Cove Base Installatin-Carpet/Gluedown	2008	806	81	10	81		370	9
10	ACS Processor (Main Phone System)	2008	1,200	120	10	120		530	10
11	New Cabinets-HCC Dining Area	2008	563	56	10	56		244	11
12	Fire Dampers in Kitchen	2008	1,600	80	20	80		367	12
13	Smoke Dect.Alarms to Fire Panel	2008	1,300	130	10	130		607	13
14	Frames for Doors	2008	2,846	284	10	284		1,162	14
15	Door & Drywall	2008	9,309	466	20	466		1,901	15
16	Sliding Front Door	2008	5,940	297	20	297		1,287	16
17	Smoke Dect.,Alarms to Fire Panel	2008	1,580	158	10	158		751	17
18	Fire Alarm Phase II	2008	3,200	320	10	320		1,280	18
19	New Roof	2008	106,223	3,540	30	3,540		15,343	19
20	Raining-Fabricate/Install on Stairs	2009	3,000	300	10	300		1,175	20
21	Door-Bookkeepers Office	2009	538	27	20	27		105	21
22	Fire System Upgrade-Phase III Part I	2009	4,553	455	10	455		1,783	22
23	Fire System Upgrade-Phase III Part II	2009	7,320	732	10	732		2,806	23
24	Stainless Steel Cabinets/Counter-HCC	2009	4,506	451	10	451		1,690	24
25	Metal Door/Kitchen	2009	1,150	115	10	115		403	25
26	Asphalt/Prime-North Parking Lot	2009	11,430	762	15	762		2,667	26
27	Kitchen Floor Renovation	2009	21,628	1,082	20	1,082		3,605	27
28	Railings-Courtyard	2009	1,920	192	10	192		640	28
29	Refrigerator Door	2009	3,500	350	10	350		1,167	29
30	Cabinets-HCC Dining Room	2009	648	65	10	65		200	30
31	Door-Life Safety Code	2009	4,680	234	20	234		702	31
32	Counter Tops for Hcc	2010	394	56	7	56		164	32
33	Sidewalk (McKinney to Morgan on Brinton)	2010	3,400	227	15	227		548	33
34	TOTAL (lines 1 thru 33)		$ 3,482,692	$ 97,797		$ 97,797	$	$ 2,384,080	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 3,482,692	$ 97,797		$ 97,797	$	$ 2,384,080	1
2	Carpet Room 37 & 38	2010	1,208	242	5	242		584	2
3	Carpet-SC	2010	631	126	5	126		294	3
4	Beauty Shop Flooring	2011	936	94	10	94		156	4
5	Parking Lot Seal Coating	2011	1,800	120	8	120		170	5
6	Water Heater	2011	1,595	160	10	160		213	6
7	Maintenance Room Steel Door	2011	978	49	20	49		53	7
8	Aluminum Floor in Walk In Cooler	2011	1,850	185	10	185		216	8
9	Automatic Sprinkler System	2012	140,225	6,427	20	6,427		6,427	9
10	Carpet - rooms 14,19 & 108	2012	3,674	245	5	245		245	10
11	Dukane Wall Station	2012	1,617	27	5	27		27	11
12	Floor Matting for Kitchen	2012	659	88	5	88		88	12
13	PTACS (Heating/AirCont.Units)	2012	22,296	557	10	557		557	13
14	Steel Door/Frame - Soc. Serv.	2012	2,861	286	10	286		286	14
15	MDS Software-PointClickCare	2012	3,543					Memo	15
16	Shunt Trip Breaker - Elevator	2012	1,983	198	10	198		198	16
17	Elevator Phone	2012	99	5	5	5		5	17
18	Circuitry,Switch,& Can Lights	2012	450	30	5	30		30	18
19	Kitchen Serve Button/Breakers	2012	1,050	70	5	70		70	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)		$ 3,670,147	$ 106,706		$ 106,706	$	$ 2,393,699	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: 01/01/12 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 793,456	$ 44,229	$ 44,229	$		$ 374,091	71
72	Current Year Purchases	39,499	1,462	1,462			1,462	72
73	Fully Depreciated Assets	(15,425)	(2,415)	(2,415)			(15,425)	73
74								74
75	TOTALS	$ 817,530	$ 43,276	$ 43,276	$		$ 360,128	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Trsansport	2004 Buick LeSabre	2012	$ 11,250	$ 950	$ 950	$	4	$ 950	76
77										77
78										78
79										79
80	TOTALS			$ 11,250	$ 950	$ 950	$		$ 950	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)	$ 4,573,130	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 150,932	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 150,932	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)	$ 2,754,777	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: 01/01/12 Ending: 12/31/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

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

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.

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

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (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	$ 146,171	$	1
2	Cash-Patient Deposits	85,067		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at cost)	37,024		4
5	Short-Term Investments			5
6	Prepaid Insurance	8,408		6
7	Other Prepaid Expenses	4,765		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest	27,575		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 309,010	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	35,000		11
12	Long-Term Investments	2,620,955		12
13	Land	74,203		13
14	Buildings, at Historical Cost	3,670,148		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	818,761		16
17	Accumulated Depreciation (book methods)	(3,009,187)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,800,585		21
22	Other Long-Term Assets (spe In Perpetual Trust	5,707,019		22
23	Other(specify): R.L. Warner Campus	188,305		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,905,789	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,214,799	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 44,435	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,363		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)**	$ 218,798	$	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)**	$ 218,798	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,996,001	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,214,799	$	48

*(See instructions.)

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,783,777	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,783,777	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	212,224	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)**	$ 212,224	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)**	$ 11,996,001	24	*

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,865,736	1
2	Discounts and Allowances for all Levels	(129,270)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,736,466	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	21,289	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 21,289	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	78	12
13	Barber and Beauty Care	2,355	13
14	Non-Patient Meals	7,365	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	11,009	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 20,807	23
	D. Non-Operating Revenue		
24	Contributions	11,698	24
25	Interest and Other Investment Income***	642,287	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 653,985	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Beneficial Trust Income(loss) on fair value	174,268	28
28a	Gain on Net Assets	41,216	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 215,484	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,648,031	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,081,816	31
32	Health Care	1,320,108	32
33	General Administration	767,130	33
	B. Capital Expense		
34	Ownership	150,932	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	115,821	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,435,807	40
41	**Income before Income Taxes (line 30 minus line 40)****	212,224	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 212,224	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 151,920	44
45	Private Pay - Net Inpatient Revenue	2,584,546	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,736,466	49

* **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.**

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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	1,987	2,201	$ 76,703	$ 34.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,584	13,940	328,637	23.58	3
4	Licensed Practical Nurses	8,101	7,372	203,569	27.61	4
5	CNAs & Orderlies	37,511	38,975	404,021	10.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,127	4,378	56,175	12.83	8
9	Activity Director	1,733	1,963	44,000	22.41	9
10	Activity Assistants	4,612	4,856	51,555	10.62	10
11	Social Service Workers	2,361	2,408	56,986	23.67	11
12	Dietician					12
13	Food Service Supervisor	1,899	2,084	36,000	17.27	13
14	Head Cook	5,710	5,851	58,644	10.02	14
15	Cook Helpers/Assistants	17,369	18,049	161,710	8.96	15
16	Dishwashers	1,841	1,969	18,393	9.34	16
17	Maintenance Workers	6,786	7,010	105,410	15.04	17
18	Housekeepers	11,553	12,442	121,901	9.80	18
19	Laundry	4,146	4,314	42,331	9.81	19
20	Administrator	2,309	2,503	95,000	37.95	20
21	Assistant Administrator					21
22	Other Administrative	2,220	2,420	57,000	23.55	22
23	Office Manager	1,903	2,084	36,600	17.56	23
24	Clerical	2,950	3,070	28,652	9.33	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	695	735	6,800	9.25	31
32	Other Health C: Scedular	1,321	1,335	13,381	10.02	32
33	Other(specify) Driver	1,448	1,541	13,779	8.94	33
34	TOTAL (lines 1 - 33)	136,166	141,500	$ 2,017,247 *	$ 14.26	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	$ 1,825	V-A-1-3	35
36	Medical Director	Contract	1,850	V-B-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	39	955	V-B-10-3	38
39	Pharmacist Consultant	43	1,560	V-B-10-3	39
40	Physical Therapy Consultant	Contract	2,625	V-B-10a-3	40
41	Occupational Therapy Consultant	Contract	1,848	V-B-10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	3	258	V-B-11-3	44
45	Social Service Consultant	5	473	V-B-12-3	45
46	Other(specify) Chaplain	Contract	2,125	V-B-11-3	46
47	Sunday Clergy		900	V-B-11-3	47
48					48
49	TOTAL (lines 35 - 48)	90	$ 14,419		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: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonnie K. O'Connell	Administrator	0	$ 95,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,000

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
EhrmannGehlbackBadger&Lee	Legal	$ 998
Green Associates	Architects	148
CliftonLarsonAllen LLP	Auditor/CPA	15,230
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 16,376

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,809
Unemployment Compensation Insurance	9,280
FICA Taxes	152,157
Employee Health Insurance	176,306
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	3,473
CPR Training	540
TOTAL (agree to Schedule V, line 22, col.8)	$ 414,565

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	$ 3,980
Advertising: Employee Recruitment	1,647
Health Care Worker Background Check	450
(Indicate # of checks performed 15)	
Patient Background Checks 18	180
LSN of Illinois	3,783
IL.Actv./Creative/Actv.Dues	145
LTCPub./Bookletts	1,299
ILNHA/CLIA	250
Non-Allowable Total	29,543
Less: Public Relations Expense	(60)
Non-allowable advertising	(24,456)
Yellow page advertising	(5,027)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,734

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MDS Seminar-Moline IL	75
Admin.CEU Confr.-Peoria IL	236
Springfield IL	390
Seminar Expense	
MDS Training/Seminar	377
Admn.Confr./ILNHA	441
IDPH Seminar-Springfield	215
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,734

**See instructions.

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

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 $3783**

(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. $ **25,699** Line **V-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. $ **115,821**
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. $ **7,898**

(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: **CliftonLarsonAllen 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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.