		FOR BHF USE					

LL1

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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 N Ottawa Ave (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 01/01/13 to 12/31/13 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: 01/01/13 Ending: 12/31/13

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	1,635	7,885		9,520	10
11	ICF/DD					11
12	SC		15,189		15,189	12
13	DD 16 OR LESS					13
14	TOTALS	1,635	23,074		24,709	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.07%

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: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	282,469	25,555	1,825	309,849		309,849		309,849			1
2	Food Purchase		268,643		268,643		268,643	(13,137)	255,506			2
3	Housekeeping	103,447	21,146	963	125,556		125,556		125,556			3
4	Laundry	67,215	16,848		84,063		84,063		84,063			4
5	Heat and Other Utilities			133,684	133,684		133,684	(17,345)	116,339			5
6	Maintenance	90,366	59,968	971	151,305		151,305	(4,431)	146,874			6
7	Other (specify):* Waste Removal			4,470	4,470		4,470		4,470			7
8	TOTAL General Services	543,497	392,160	141,913	1,077,570		1,077,570	(34,913)	1,042,657			8
	B. Health Care and Programs											
9	Medical Director			1,900	1,900		1,900		1,900			9
10	Nursing and Medical Records	1,105,118	55,881	2,534	1,163,533		1,163,533	(206)	1,163,327			10
10a	Therapy	58,624		4,300	62,924		62,924		62,924			10a
11	Activities	100,064	6,745	4,740	111,549		111,549	(60)	111,489			11
12	Social Services	57,590	3,585	1,580	62,755		62,755		62,755			12
13	CNA Training											13
14	Program Transportation		2,575		2,575		2,575	(402)	2,173			14
15	Other (specify):* Nur.Rehab Training			899	899		899		899			15
16	TOTAL Health Care and Programs	1,321,396	68,786	15,953	1,406,135		1,406,135	(668)	1,405,467			16
	C. General Administration											
17	Administrative	95,000			95,000		95,000		95,000			17
18	Directors Fees											18
19	Professional Services			15,819	15,819		15,819	(359)	15,460			19
20	Dues, Fees, Subscriptions & Promotions			36,524	36,524		36,524	(27,299)	9,225			20
21	Clerical & General Office Expenses	139,358	15,733	18,257	173,348		173,348	(8,491)	164,857			21
22	Employee Benefits & Payroll Taxes			472,245	472,245		472,245		472,245			22
23	Inservice Training & Education			806	806		806		806			23
24	Travel and Seminar			1,160	1,160		1,160		1,160			24
25	Other Admin. Staff Transportation			118	118		118		118			25
26	Insurance-Prop.Liab.Malpractice			36,572	36,572		36,572		36,572			26
27	Other (specify):* Satisfac.ofContrib.			2,860	2,860		2,860	(2,860)				27
28	TOTAL General Administration	234,358	15,733	584,361	834,452		834,452	(39,009)	795,443			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,099,251	476,679	742,227	3,318,157		3,318,157	(74,590)	3,243,567			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:** 01/01/13 **Ending:** 12/31/13

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			159,952	159,952		159,952		159,952			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(729,669)	(729,669)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			159,952	159,952		159,952	(729,669)	(569,717)			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			70,786	70,786		70,786		70,786			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			70,786	70,786		70,786		70,786			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,099,251	476,679	972,965	3,548,895		3,548,895	(804,259)	2,744,636			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: 01/01/13 Ending: 12/31/13

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	13,137	V-A2-7		4
5	Telephone, TV & Radio in Resident Rooms	17,345	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	729,669	V-D-32-7		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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	359	V-C-19-7		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	22,908	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	4,391	V-C-20-7		28
29	Other-Attach Schedule	16,450			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 804,259		$	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))**	$ 804,259		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: 01/01/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nursing-Misc. Supplies (Name Tags)	$ 206	V-B-10-7	1
2	Tune Piano	60	V-B-11-7	2
3	Fuel for Lawn Mower/Snow Plow	402	V-B-14-7	3
4	Contribution Booklets	930	V-C-21-7	4
5	Employee Apprec, Flowers, etc. thruout year	7,561	V-C-21-7	5
6	Satisfaction of Restricted Funds	2,860	V-C-27-7	6
7	Maintenance-Grounds,seeds,fertilizer	4,431	V-A-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**	16,450		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Square # 0018176 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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	(13,137)	0	0	0	0	0	0	0	0	0	0	(13,137)	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	(17,345)	0	0	0	0	0	0	0	0	0	0	(17,345)	5
6	Maintenance	(4,431)	0	0	0	0	0	0	0	0	0	0	(4,431)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(34,913)	0	0	0	0	0	0	0	0	0	0	(34,913)	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	(206)	0	0	0	0	0	0	0	0	0	0	(206)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(60)	0	0	0	0	0	0	0	0	0	0	(60)	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	(402)	0	0	0	0	0	0	0	0	0	0	(402)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(668)	0	0	0	0	0	0	0	0	0	0	(668)	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	(359)	0	0	0	0	0	0	0	0	0	0	(359)	19
20	Fees, Subscriptions & Promotions	(27,299)	0	0	0	0	0	0	0	0	0	0	(27,299)	20
21	Clerical & General Office Expenses	(8,491)	0	0	0	0	0	0	0	0	0	0	(8,491)	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):* Satisfac.ofContril	(2,860)	0	0	0	0	0	0	0	0	0	0	(2,860)	27
28	**TOTAL General Administration**	(39,009)	0	0	0	0	0	0	0	0	0	0	(39,009)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(74,590)	0	0	0	0	0	0	0	0	0	0	(74,590)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Square **#** 0018176 **Report Period Beginning:** 01/01/13 **Ending:** 12/31/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	(729,669)	0	0	0	0	0	0	0	0	0	0	(729,669)	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**	(729,669)	0	0	0	0	0	0	0	0	0	0	(729,669)	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)**	(804,259)	0	0	0	0	0	0	0	0	0	0	(804,259)	45

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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,Sr.-Vice-President	BOD						3
4	Judge 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: 01/01/13 Ending: 12/31/13

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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:** 01/01/13 **Ending:** 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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 2013 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:		
2008		8
2009		9
2010		10
2011		11
2012		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 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 2012 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 2012.

	(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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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	$	$ 1,503,451	4
5			1993	1993	1,100,199	27,505	40	27,505		563,852	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	Sprinklers LL Store			1981	1,309		20			1,309	11
12	P.T. Room			1985	18,461		18			18,461	12
13	Activity Room LL			1988	3,229		19			3,229	13
14	Soc.Service Office			1988	1,319		5			1,319	14
15	New Roof HCC			1988	5,940		15			5,940	15
16	Parking Lot			1989	11,398		20			11,398	16
17	Drain Line Trough			1991	2,099		5			2,099	17
18	Stoarage Shed			1991	1,189		20			1,189	18
19	Fire Alarm Wiring			1991	1,630		5			1,630	19
20	Gutter & Downspouts (S.Wing)			1991	4,500		5			4,500	20
21	Intercom improvement			1992	508		15			508	21
22	Beam Fire Protection			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	Concrete Walk & Bench Pad			1994	1,225	96	20	96		1,225	27
28	Heating Units			1994	3,966		10			3,966	28
29	Safety Door Shield			1994	1,250		10			1,250	29
30	Paint Facia of Building			1994	1,955		5			1,955	30
31	Life Safety Door Closer (replace)			1995	4,432		5			4,432	31
32	Patio Sidewalk (Replace)			1995	6,507	309	20	309		5,822	32
33	Soffit Repair (Vinyl)			1995	4,100	195	20	195		3,670	33
34	Attic Ventilation South			1996	11,600	551	20	551		9,802	34
35	Walk Drive Approach			1996	3,809	181	20	181		3,217	35
36	See next page										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: 01/01/13 Ending: 12/31/13

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	Storage Shed	1996	$ 707	$ 34	20	$ 34	$	$ 597	37
38	Lighting Replacement (Energy Efficient)	1997	13,031	202	15	202		13,031	38
39	Radiant Heat Panels	1998	19,894		10			19,894	39
40	8 Attic Exhaust Fans	1998	6,356	302	20	302		4,683	40
41	Kitchen Fire Systems	1998	898	43	20	43		651	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		2,996	44
45	Paint Halls & Doors	2001	5,970		5			5,970	45
46	New South Roof	2002	171,935	5,731	30	5,731		64,475	46
47	New North Roof	2003	140,137	4,671	30	4,671		47,491	47
48	Bathroom Tile	2005	1,500	75	20	75		663	48
49	Replacement of PVC & Clay Tile & Pvc	2005	1,153	38	30	38		329	49
50	Repair & Waterproof Balcony	2005	6,500	325	20	325		2,735	50
51	Exit/Cylinder Change Room Doors	2005	4,426	221	20	221		1,862	51
52	Prime & Paint Handrail on Bldg.	2005	3,360	336	10	336		2,772	52
53	Repair & Blacktop North Driveway	2005	9,330	622	15	622		5,028	53
54	New Locks for half of Resi.rooms	2006	2,897	145	20	145		1,099	54
55	Carpet for offices and entrance	2006	7,307		5			7,307	55
56	Concrete Work	2006	2,595	173	15	173		1,269	56
57	Asphalt half circle driveway	2006	2,300	153	15	153		1,111	57
58	Automatic Door for Courtyard	2006	2,665	133	20	133		955	58
59	Metal Wall	2007	9,523	476	20	476		3,174	59
60	Commodes	2007	1,366	137	10	137		911	60
61	Carpet	2007	3,014	301	10	301		1,984	61
62	Fire Alarm Control Panel	2007	8,000	800	10	800		5,267	62
63	Smoke Detectors/horns/strobes	2007	8,763	876	10	876		5,696	63
64	Concrete Patio	2007	5,860	293	20	293		5,860	64
65	Wall Station Dukane 4A1225	2007	723		5			723	65
66	Floor Pedal Sink	2007	380	38	10	38		244	66
67	Actuator (Lifts) 2	2007	1,072	107	10	107		679	67
68	IDPH Fire Improvements	2007	8,755	438	20	438		2,627	68
69	cont'd on next page								69
70	TOTAL (lines 4 thru 69)		$ 3,232,374	$ 84,037		$ 84,037	$	$ 2,418,412	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: 01/01/13 Ending: 12/31/13

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	$ 84,037		$ 84,037	$	$ 2,418,412	1
2	IDPH Fire Improvements-Doors,Frames,Hardware	2008	19,090	955	20	955		5,727	2
3	IDPH Improvements-Luse Thermal Firestopping	2008	11,580	579	20	579		3,426	3
4	New Locks for Residents	2008	2,786	139	20	139		812	4
5	New Carpet	2008	1,511	151	10	151		869	5
6	Smoke Dect.,Alarms to Fire Panel	2008	1,580	158	10	158		909	6
7	IDPH-RollingFireDoor	2008	10,247	512	20	512		2,903	7
8	Smoke,Dectectors,Alarms,etc.	2008	1,300	130	10	130		737	8
9	Fire Dampers in Kitchen	2008	1,600	80	20	80		1,600	9
10	GlueDownCarpet,CoveBaseInstall	2008	806	81	10	81		451	10
11	ACS Processor (Main Phone System)	2008	1,200	120	10	120		650	11
12	New Cabinets (HCC)	2008	563	56	10	56		300	12
13	Sliding Door	2008	5,940	297	20	297		1,584	13
14	New Roof	2008	106,223	3,541	30	3,541		18,884	14
15	New Carpet for Unit A	2008	806	81	10	81		417	15
16	Frames for Doors	2008	2,846	285	10	285		1,447	16
17	Doors & Drywall	2008	9,309	465	20	465		2,366	17
18	Fire Alarm Phase II	2008	3,200	320	10	320		1,600	18
19	Creamic tile for 2nd Flr Dining room	2008	1,064	106	10	106		532	19
20	Fabricate & Install Railings on Stairs	2009	3,000	300	10	300		1,475	20
21	Bookkeeper's Door	2009	538	27	20	27		132	21
22	Fire System Update - Phase III	2009	4,553	455	10	455		2,238	22
23	Fire System Update - Phase III	2009	7,320	732	10	732		3,538	23
24	Stainless Steel Bench/Counter/Cabinet	2009	4,506	451	10	451		2,141	24
25	Hollow Metal Door/Kitchen	2009	1,150	115	10	115		518	25
26	Prime & Ashpalt Parking Lot	2009	11,430	762	15	762		3,429	26
27	Kitchen Renovation	2009	21,628	1,081	20	1,081		4,686	27
28	Fabricate Railing for Court Yark	2009	1,920	192	10	192		832	28
29	Refrigerator Door	2009	3,500	350	10	350		1,517	29
30	Cabinets-HCC Dining Room	2009	648	65	10	65		265	30
31	Door-Life Safety Code	2009	4,680	234	20	234		936	31
32	Counter Tops for HCC	2010	394	56	7	56		220	32
33	Cont'd on 12C								33
34	TOTAL (lines 1 thru 33)		$ 3,479,292	$ 96,913		$ 96,913	$	$ 2,485,553	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: 01/01/13 Ending: 12/31/13

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		$ 3,479,292	$ 96,913		$ 96,913	$	$ 2,485,553	1
2	Sidewalk-McKinnytoMorganonBrinton	2010	3,400	227	15	227		775	2
3	Carpet Room 37 & 38	2010	1,208	242	5	242		826	3
4	Carpet	2010	631	126	5	126		420	4
5	Beauty Shop Flooring	2011	936	94	10	94		250	5
6	Parking Lot Seal Coating	2011	1,800	120	15	120		290	6
7	Water Heater Powers Series 430	2011	1,595	160	10	160		373	7
8	Aluminum Floor in Walk in Cooler	2011	1,850	185	10	185		401	8
9	Maintenance Room Steel Door	2011	978	49	20	49		102	9
10	Steel Door/Frame-Soc.Svc.	2012	2,861	286	10	286		572	10
11	Shunt Trip Breaker-Elevator	2012	1,983	198	10	198		396	11
12	Automatic Sprinkler System	2012	140,225	7,011	20	7,011		13,438	12
13	Floor Matting for Kitchen	2012	659	132	5	132		220	13
14	Circuitry,Switch, & Can Lights - Dining Room	2012	450	90	5	90		120	14
15	Carpet-Rooms 14,19 & 108	2012	3,674	735	5	735		980	15
16	Kitchen Servce Button/Breakers	2012	1,050	210	5	210		280	16
17	Elevator Phone	2012	99	20	5	20		25	17
18	PTACS	2012	22,296	2,230	10	2,230		2,787	18
19	MDS Software-PointClickCare	2012	3,543						19
20	Dukane Wall Station	2012	1,617	323	5	323		350	20
21	Stainless Steel Cover for Ice Chest	2013	795	146	5	146		146	21
22	Water Heater	2013	24,114	2,009	10	2,009		2,009	22
23	Washer	2013	7,539	1,257	5	1,257		1,257	23
24	HP Printer HCC	2013	771	116	5	116		116	24
25	Mixer Valve for Water Heater	2013	2,075	311	5	311		311	25
26	PTACS	2013	14,857	1,733	5	1,733		1,733	26
27	Wireless/Computer for HCC	2013	7,371	860	5	860		860	27
28	Fax Machines-Brother Intelli.HCC/SC	2013	1,000	83	5	83		83	28
29	Heat/Cool Unit (Hallway)	2013	2,750	229	5	229		229	29
30	Concrete Sidewalk-North End	2013	6,775	565	5	565		565	30
31	Computer & Monitor for Activies/Programs	2013	1,181	79	5	79		79	31
32	Computer Administrator	2013	953	48	5	48		953	32
33	Cont'd on Page 12D								33
34	TOTAL (lines 1 thru 33)		$ 3,740,328	$ 116,787		$ 116,787	$	$ 2,516,499	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: 01/01/13 Ending: 12/31/13

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 12C, Carried Forward		$ 3,740,328	$ 116,787		$ 116,787	$	$ 2,516,499	1
2	Tile - HCC	2013	1,323	66	5	66		66	2
3	2 Fire Rings - Per IDPH	2013	403	20	5	20		20	3
4	Carpet - Room 11	2013	885	30	5	30		30	4
5	Generator Circuts	2013	7,984	133	5	133		133	5
6	Electrical Upgrade on HCC	2013	1,500	25	5	25		25	6
7	MDS Software-PointClickCare	2013	15,929	266	5	266		266	7
8	Stainless Plates for Dining Room Wall	2013	741		5				8
9	Carpet - Room 5 SC	2013	931		5				9
10	Concentrator	2013	570		5				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)		$ 3,770,594	$ 117,327		$ 117,327	$	$ 2,517,039	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: 01/01/13 Ending: 12/31/13

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	$ 817,530	$ 43,276	$ 43,276	$		$ 360,128	71
72	Current Year Purchases	7,270	491	491			491	72
73	Fully Depreciated Assets	(44,433)	(3,423)	(3,423)			(3,423)	73
74								74
75	TOTALS	$ 780,367	$ 40,344	$ 40,344	$		$ 357,196	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 Transport	2004 Buick LeSabre	2012	$ 11,405	$ 2,281	$ 2,281	$		$ 3,231	76
77										77
78										78
79										79
80	TOTALS			$ 11,405	$ 2,281	$ 2,281	$		$ 3,231	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)	$ 4,636,569	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 159,952	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 159,952	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)	$ 2,877,466	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: 01/01/13 Ending: 12/31/13

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: 01/01/13 Ending: 12/31/13

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 ☐ 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.

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/13 (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	$ 137,267	$	1
2	Cash-Patient Deposits	60,116		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at cost)	36,184		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,478		6
7	Other Prepaid Expenses	5,051		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest	22,993		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 267,089	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,731,244		12
13	Land	74,203		13
14	Buildings, at Historical Cost	3,761,776		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	764,302		16
17	Accumulated Depreciation (book methods)	(3,102,135)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,832,398		21
22	Other Long-Term Assets (spe In Perpetual Trust	5,488,798		22
23	Other(specify): R.L. Warner Campus	188,305		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,738,891	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,005,980	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 49,986	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	166,034		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)**	$ 216,020	$	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)**	$ 216,020	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,789,960	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,005,980	$	48

*(See instructions.)

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,996,001	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,996,001	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(206,041)	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)**	$ (206,041)	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)**	$ 11,789,960	24	*

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	$ 2,890,820	1
2	Discounts and Allowances for all Levels	(123,317)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,767,503	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	24,596	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 24,596	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	2,500	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	77	12
13	Barber and Beauty Care	2,155	13
14	Non-Patient Meals	11,858	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	10,179	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 26,769	23
	D. Non-Operating Revenue		
24	Contributions	11,637	24
25	Interest and Other Investment Income***	729,669	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 741,306	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Beneficial Trust Income(loss) on fair value	(218,221)	28
28a	Gain(Loss)in Fair	901	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (217,320)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,342,854	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,077,570	31
32	Health Care	1,406,135	32
33	General Administration	834,452	33
	B. Capital Expense		
34	Ownership	159,952	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	70,786	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,548,895	40
41	**Income before Income Taxes (line 30 minus line 40)****	(206,041)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (206,041)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 158,825	44
45	Private Pay - Net Inpatient Revenue	2,608,678	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)	$ 2,767,503	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.**

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	2,485	2,573	$ 55,000	$ 21.38	1
2	Assistant Director of Nursing	1,690	2,044	50,758	24.83	2
3	Registered Nurses	12,542	12,976	326,359	25.15	3
4	Licensed Practical Nurses	8,990	9,441	221,521	23.46	4
5	CNAs & Orderlies	38,538	39,638	443,955	11.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,968	4,243	58,624	13.82	8
9	Activity Director	1,663	1,836	45,325	24.69	9
10	Activity Assistants	4,917	5,105	54,739	10.72	10
11	Social Service Workers	4,312	4,578	57,590	12.58	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,095	36,725	17.53	13
14	Head Cook	6,094	6,415	64,700	10.09	14
15	Cook Helpers/Assistants	16,739	17,272	158,289	9.16	15
16	Dishwashers	2,214	2,393	22,755	9.51	16
17	Maintenance Workers	5,321	5,602	90,366	16.13	17
18	Housekeepers	10,130	10,655	103,336	9.70	18
19	Laundry	5,916	6,218	67,215	10.81	19
20	Administrator	2,416	2,542	95,000	37.37	20
21	Assistant Administrator					21
22	Other Administrative	1,949	2,092	60,000	28.68	22
23	Office Manager	1,998	2,264	38,860	17.16	23
24	Clerical	3,029	3,163	30,489	9.64	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	429	464	4,254	9.17	31
32	Other Health C: Scheduler	295	327	3,272	10.01	32
33	Other(specify) Driver	1,047	1,124	10,119	9.00	33
34	TOTAL (lines 1 - 33)	138,634	145,060	$ 2,099,251 *	$ 14.47	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	1,900	V-B-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	37	1,013	V-B-10-3	38
39	Pharmacist Consultant	35	1,395	V-B-10-3	39
40	Physical Therapy Consultant	Contract	2,090	V-B-10a-3	40
41	Occupational Therapy Consultant	Contract	1,242	V-B-10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Contract	968		43
44	Activity Consultant	20	1,580	V-B-11-3	44
45	Social Service Consultant	20	1,580	V-B-12-3	45
46	Other(specify) Chaplain	Contract	2,075	V-B-1-3	46
47	Sunday Clergy	40	1,025	V-B-11-3	47
48	MDS Software/Computer Svcs	Contract	6,968	V-B-10-3	48
49	TOTAL (lines 35 - 48)	152	$ 23,661		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: 01/01/13 Ending: 12/31/13

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
EhrmannGehlbachBadger &		$
Lee, Considine	Legal	359
CliftonLarsonAllenLLP	Auditor/CPA	15,460
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 15,819

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,557
Unemployment Compensation Insurance	1,795
FICA Taxes	157,605
Employee Health Insurance	233,273
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	3,575
CPR Training	440
TOTAL (agree to Schedule V, line 22, col.8)	$ 472,245

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	2,050
Health Care Worker Background Check	480
(Indicate # of checks performed 16)	
Patient Background Checks 19	190
LSN of Illinois	3,891
IL.Actv./Creative/Actv.Dues	261
LTC.Pub/State of IL	236
Non-Allowable Total	27,299
Less: Public Relations Expense	(211)
Non-allowable advertising	(22,570)
Yellow page advertising	(4,391)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,225

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
IDPH Seminar-Springfield	300
Seminar Expense	
LSN HIPAAA	185
IDPH Seminar-Springfield	315
JCM Institute	360
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,160

**See instructions.

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/13 Ending: 12/31/13

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: 01/01/13 Ending: 12/31/13

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 Servies Network $3741**

(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? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,408** 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. $ **70,786**
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. $ **13,137**

(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? **92%**
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 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.