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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0018176

Facility Name: Heritage Square

Address: 620 North 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 01/01/2014 to 12/31/2014 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: 01/01/2014 Ending: 12/31/2014

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	1,445	7,799		9,244	10
11	ICF/DD					11
12	SC		15,330		15,330	12
13	DD 16 OR LESS					13
14	TOTALS	1,445	23,129		24,574	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.59%

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: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Heritage Square # 0018176 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	285,491	26,196	1,825	313,512		313,512		313,512			1
2	Food Purchase		275,727		275,727		275,727	(14,670)	261,057			2
3	Housekeeping	113,430	21,139	885	135,454		135,454		135,454			3
4	Laundry	62,221	15,274		77,495		77,495		77,495			4
5	Heat and Other Utilities			136,277	136,277		136,277	(16,666)	119,611			5
6	Maintenance	91,182	79,611	595	171,388		171,388	(6,572)	164,816			6
7	Other (specify):* **Waste Removal**			4,951	4,951		4,951		4,951			7
8	**TOTAL General Services**	552,324	417,947	144,533	1,114,804		1,114,804	(37,908)	1,076,896			8
	B. Health Care and Programs											
9	Medical Director			1,900	1,900		1,900		1,900			9
10	Nursing and Medical Records	1,091,091	59,607	5,881	1,156,579		1,156,579	(34)	1,156,545			10
10a	Therapy	65,256		2,211	67,467		67,467		67,467			10a
11	Activities	108,849	6,542	3,682	119,073		119,073	(70)	119,003			11
12	Social Services	57,941	1,119	632	59,692		59,692	(72)	59,620			12
13	CNA Training											13
14	Program Transportation		2,699	815	3,514		3,514	(603)	2,911			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,323,137	69,967	15,121	1,408,225		1,408,225	(779)	1,407,446			16
	C. General Administration											
17	Administrative	95,000			95,000		95,000		95,000			17
18	Directors Fees											18
19	Professional Services			15,365	15,365		15,365	(200)	15,165			19
20	Dues, Fees, Subscriptions & Promotions			40,567	40,567		40,567	(28,840)	11,727			20
21	Clerical & General Office Expenses	130,522	16,711	12,018	159,251		159,251	(5,129)	154,122			21
22	Employee Benefits & Payroll Taxes			533,265	533,265		533,265		533,265			22
23	Inservice Training & Education			175	175		175		175			23
24	Travel and Seminar			1,211	1,211		1,211		1,211			24
25	Other Admin. Staff Transportation			101	101		101		101			25
26	Insurance-Prop.Liab.Malpractice			40,262	40,262		40,262		40,262			26
27	Other (specify):* **Bad Debt**			29,319	29,319		29,319	(29,319)				27
28	**TOTAL General Administration**	225,522	16,711	672,283	914,516		914,516	(63,488)	851,028			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,100,983	504,625	831,937	3,437,545		3,437,545	(102,175)	3,335,370			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:** 01/01/2014 **Ending:** 12/31/2014

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			161,569	161,569		161,569		161,569			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(572,340)	(572,340)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			161,569	161,569		161,569	(572,340)	(410,771)			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			70,211	70,211		70,211		70,211			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			70,211	70,211		70,211		70,211			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,100,983	504,625	1,063,717	3,669,325		3,669,325	(674,515)	2,994,810			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: 01/01/2014 Ending: 12/31/2014

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	14,670	V-A2-7		4
5	Telephone, TV & Radio in Resident Rooms	16,666	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	572,340	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	5,129	V-C-21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	200	V-C-19-7		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	29,319	V-C-27-7		24
25	Fund Raising, Advertising and Promotional	25,208	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	3,632	V-C-20-7		28
29	Other-Attach Schedule	7,351			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 674,515		$	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))**	$ 674,515		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: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Maintenance-Grounds,seeds,fertilizer,tree removal	$ 6,572	V-A-6-7	1
2	Nursing - Name Tags	34	V-B-10-7	2
3	Activities/Programs-Piano Tuner	70	V-B-11-7	3
4	Social-Services-Notary Stamp	22	V-B-12-7	4
5	Social-Services-GiftCard	50	V-B-12-7	5
6	Program-Transportation-Mower,Grounds	603	V-B-14-7	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	7,351		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Square **#** 0018176 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(14,670)	0	0	0	0	0	0	0	0	0	0	(14,670)	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	(16,666)	0	0	0	0	0	0	0	0	0	0	(16,666)	5
6	Maintenance	(6,572)	0	0	0	0	0	0	0	0	0	0	(6,572)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(37,908)	0	0	0	0	0	0	0	0	0	0	(37,908)	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	(34)	0	0	0	0	0	0	0	0	0	0	(34)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(70)	0	0	0	0	0	0	0	0	0	0	(70)	11
12	Social Services	(72)	0	0	0	0	0	0	0	0	0	0	(72)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(603)	0	0	0	0	0	0	0	0	0	0	(603)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(779)	0	0	0	0	0	0	0	0	0	0	(779)	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	(200)	0	0	0	0	0	0	0	0	0	0	(200)	19
20	Fees, Subscriptions & Promotions	(28,840)	0	0	0	0	0	0	0	0	0	0	(28,840)	20
21	Clerical & General Office Expenses	(5,129)	0	0	0	0	0	0	0	0	0	0	(5,129)	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):* **Bad Debt**	(29,319)	0	0	0	0	0	0	0	0	0	0	(29,319)	27
28	**TOTAL General Administration**	(63,488)	0	0	0	0	0	0	0	0	0	0	(63,488)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(102,175)	0	0	0	0	0	0	0	0	0	0	(102,175)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Square # 0018176 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(572,340)	0	0	0	0	0	0	0	0	0	0	(572,340)	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**	(572,340)	0	0	0	0	0	0	0	0	0	0	(572,340)	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)**	(674,515)	0	0	0	0	0	0	0	0	0	0	(674,515)	45

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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-6 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: 01/01/2014 Ending: 12/31/2014

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 Collines-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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 2/31/2014

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: 01/01/2014 Ending: 12/31/2014

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:** 01/01/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:			
	2009		8
	2010		9
	2011		10
	2012		11
	2013		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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	$ 28,630	40	$ 28,630	$	$ 1,532,081	4
5			1993	1993	1,100,199	27,505	40	27,505		591,357	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	P.T. Room			1985	18,461		18			18,461	11
12	Activity Room LL			1985	3,229		15			3,229	12
13	Soc.Service Office			1988	1,319		5			1,319	13
14	New Roof HCC			1988	5,940		15			5,940	14
15	Parking Lot			1989	11,398		5			11,398	15
16	Drain Line Trough			1991	2,099		5			2,099	16
17	Storage Shed			1991	1,189		20			1,189	17
18	Fire Alarm Wiring			1991	1,630		5			1,630	18
19	Gutter & Downspouts (S. Wing)			1991	4,500		5			4,500	19
20	Intercom improvement			1992	508		15			508	20
21	Beam Fire Protection			1993	1,380		10			1,380	21
22	Concrete Walk & Driveway			1993	6,008		15			6,008	22
23	Landscaping (New Wing)			1993	7,749		10			7,749	23
24	Resurface Parking Lot			1993	17,716		15			17,716	24
25	Gutter Downspouts (N. Wing)			1993	3,600		15			3,600	25
26	Concrete Walk & Bench Pad			1994	1,225		20			1,225	26
27	Safety Door Shield			1994	1,250		10			1,250	27
28	Paint Facia of Building			1994	1,955		5			1,955	28
29	Life Safety Door Closer (replace)			1995	4,432		15			4,432	29
30	Patio Sidewalk (replace)			1995	6,507	309	20	309		6,131	30
31	Soffit Repair (Vinyl)			1995	4,100	195	20	195		3,865	31
32	Attic Ventilation South			1996	11,600	551	20	551		10,353	32
33	Walk Drive Approach			1996	3,809	181	20	181		3,398	33
34	Storage Shed			1996	707	34	20	34		631	34
35	Lighting Replacement (Energy Efficient)			1997	13,031		15			13,031	35
36	See Page 12A										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Radiant Heat Panels	1998	$ 19,894	$	10	$	$	$ 19,894	37
38	8 Attic Exhaust Fans	1998	6,356	302	20	302		4,985	38
39	Kitchen Fire Systems	1998	898	43	20	43		694	39
40	Painting	1999	11,227		5			11,227	40
41	Deposit Bldg.Extens.	2000	2,346						41
42	GFI Electric Upgrades	2000	4,800	228	20	228		3,224	42
43	Paint Halls & Doors	2001	5,970		5			5,970	43
44	New South Roof	2002	171,935	5,731	30	5,731		70,206	44
45	New North Roof	2003	140,137	4,671	30	4,671		52,162	45
46	Bathroom Tile	2005	1,500	75	20	75		738	46
47	Replacetment of PVC & Clay Tile/Sewer	2005	1,153	38	30	38		367	47
48	Repair & Waterproof Balcony decks	2005	6,500	325	20	325		3,060	48
49	Exit/Cylinder Change Room Doors	2005	4,426	221	20	221		2,083	49
50	Prime & Paint Handrail on Bldg.	2005	3,360	336	10	336		3,108	50
51	Repair & Blacktop North Driveway	2005	9,330	622	15	622		5,650	51
52	New locks for half of the resident rooms	2006	2,897	145	20	145		1,244	52
53	Carpet for Offices and entrance	2006	7,307		5			7,307	53
54	Concrete Work	2006	2,595	173	15	173		1,442	54
55	Asphalt Half Circle driveway	2006	2,300	153	15	153		1,264	55
56	Automatic Door for Courtyard	2006	2,665	133	20	133		1,088	56
57	Metal Wall	2007	9,523	476	20	476		3,650	57
58	Commodes	2007	1,366	137	10	137		1,048	58
59	Carpet	2007	3,014	301	10	301		2,285	59
60	Fire Alarm Control Panel	2007	8,000	800	10	800		6,067	60
61	Smoke Detectors/horns/strobes	2007	8,763	876	10	876		6,572	61
62	Concrete Patio	2007	5,860	293	20	293		2,198	62
63	Wall Station Dukane 4A1225	2007	723		5			723	63
64	Floor Pedal Sink	2007	380	38	10	38		282	64
65	Actuator (Lifts) 2	2007	1,072	107	10	107		786	65
66	IDPH Fire Improvements	2007	8,755	438	20	438		3,065	66
67	IDPH Fire Improvements-Doors,frames,hardware	2008	19,090	955	20	955		6,682	67
68	IDPH Improvements-Luse Thermal firestopping	2008	11,580	579	20	579		4,005	68
69	New Locks for Residents	2008	2,786	139	20	139		951	69
70	TOTAL (lines 4 thru 69)		$ 3,260,555	$ 75,740		$ 75,740	$	$ 2,494,887	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: 01/01/2014 Ending: 12/31/2014

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		$ 3,260,555	$ 75,740		$ 75,740	$	$ 2,494,887	1
2	New Carpet	2008	1,511	151	10	151		1,020	2
3	Smoke Detector, Door Alarm Lite	2008	1,580	158	10	158		1,067	3
4	IDPH-RollingFireDoor	2008	10,247	512	20	512		3,415	4
5	Smoke,Dectector,Alarms,etc.	2008	1,300	130	10	130		867	5
6	Fire Dampers in Kitchen	2008	1,600	80	20	80		527	6
7	GlueDownCarpet,CoveBaseInstall	2008	806	81	10	81		532	7
8	ACS Processor (Main Phone System)	2008	1,200	120	10	120		770	8
9	New Cabinets (HCC)	2008	563	56	10	56		356	9
10	Sliding Door	2008	5,940	297	20	297		1,881	10
11	New Roof	2008	106,223	3,541	30	3,541		22,425	11
12	New Carpet for Unit A	2008	806	81	10	81		498	12
13	Frames for Doors	2008	2,846	285	10	285		1,732	13
14	Doors & Drywell	2008	9,309	465	20	465		2,831	14
15	Fire Alarm Phase II	2008	3,200	320	10	320		1,920	15
16	Creamic Tile for 2nd Floor Dining Room	2008	1,064	106	10	106		638	16
17	Fabricate & Install Railings on Stairs	2009	3,000	300	10	300		1,775	17
18	Bookkeeper's Door	2009	538	27	20	27		159	18
19	Fire System Update - Phase III	2009	4,553	455	10	455		2,693	19
20	Fire System Update - Phase III	2009	7,320	732	10	732		4,270	20
21	Stainless Steel Bench/Counter/Cabinets	2009	4,506	451	10	451		2,592	21
22	Hollow Metal Door/Kitchen	2009	1,150	115	10	115		633	22
23	Prime & Asphalt Parking Lot	2009	11,430	762	15	762		4,191	23
24	Kitchen Renovation	2009	21,628	1,081	20	1,081		5,767	24
25	Fabricate Railing for Court Yard	2009	1,920	192	10	192		1,024	25
26	Refrigerator Door	2009	3,500	350	10	350		1,867	26
27	Cabinets-HCC Dining Room	2009	648	65	10	65		330	27
28	Door-Life Safety Code	2009	4,680	234	20	234		1,170	28
29	Counter Tops for HCC	2010	394	56	7	56		276	29
30	Sidewalk-McKinney to Morgan on Brinton	2010	3,400	227	15	227		1,002	30
31	Carpet Room 37 & 38	2010	1,208	242	5	242		1,068	31
32	Carpet	2010	631	126	5	126		546	32
33	Cont'd on 12C								33
34	TOTAL (lines 1 thru 33)		$ 3,479,256	$ 87,538		$ 87,538	$	$ 2,564,729	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: 01/01/2014 Ending: 12/31/2014

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		$ 3,479,256	$ 87,538		$ 87,538	$	$ 2,564,729	1
2	Beauty Shop Flooring	2011	936	94	10	94		344	2
3	Parking Lot Seal Coating	2011	1,800	120	15	120		410	3
4	Water Heater Powers Series 430	2011	1,595	160	10	160		533	4
5	Aluminum Floor in Walk In Cooler	2011	1,850	185	10	185		586	5
6	Maintenance Room Steel Door	2011	978	49	20	49		151	6
7	Steel Door/Frame-Soc.Sec.	2012	2,861	286	10	286		858	7
8	Shunt Trip Breaker-Elevator	2012	1,983	198	10	198		594	8
9	Automatic Sprinkler System	2012	140,225	7,011	20	7,011		20,449	9
10	Floor Matting for Kitchen	2012	659	132	5	132		352	10
11	Circuitry,Switch, & Can Lights-Dining Room	2012	450	90	5	90		210	11
12	Carpet-Rooms 14,19 & 108	2012	3,674	735	5	735		1,715	12
13	Kitchen Service Button/Breakers	2012	1,050	210	5	210		490	13
14	Elevator Phone	2012	99	20	5	20		45	14
15	PTACS	2012	22,296	2,230	10	2,230		5,017	15
16	Dukane Wall Station	2012	1,617	323	5	323		673	16
17	Stainless Steel Cover for Ice Chest	2013	795	159	5	159		305	17
18	Water Heater	2013	24,114	2,411	10	2,411		4,420	18
19	Washer	2013	7,539	1,508	5	1,508		2,765	19
20	Printer-HCC	2013	771	154	5	154		270	20
21	Mixer Valve for Water Heater	2013	2,075	415	5	415		726	21
22	PTACS	2013	14,857	2,971	5	2,971		4,704	22
23	Wireless/Computer for HCC	2013	7,371	1,474	5	1,474		2,334	23
24	Fax Machines	2013	1,000	200	5	200		283	24
25	Heat/Cool Unit	2013	2,750	550	5	550		779	25
26	Concrete Sidewalk-North End	2013	6,775	1,355	5	1,355		1,920	26
27	Computer/Monitor for Actv./Programs	2013	1,181	236	5	236		315	27
28	Computer-Administrator	2013	953	191	5	191		239	28
29	Tile - HCC Room	2013	1,323	265	5	265		331	29
30	2 Fire Rings-Per IDPH	2013	403	81	5	81		101	30
31	Carpet - Room 11	2013	885	177	5	177		207	31
32	Generator Circuits	2013	7,984	1,597	5	1,597		1,730	32
33	Cont'd on Page 12D								33
34	TOTAL (lines 1 thru 33)		$ 3,742,105	$ 113,125		$ 113,125	$	$ 2,618,585	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: 01/01/2014 Ending: 12/31/2014

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		$ 3,742,105	$ 113,125		$ 113,125	$	$ 2,618,585	1
2	Electrical Upgrade on HCC	2013	1,500	300	5	300		325	2
3	MDS Software-PCC	2013	15,929	3,186	5	3,186		3,452	3
4	Stainless Plates for Dining Room Wall	2013	741	148	5	148		148	4
5	Carpet - Room 5 SC	2013	931	186	5	186		186	5
6	Concentrator	2013	570	114	5	114		114	6
7	Addtn'l Water Heater Costs	2014	1,040	104	10	104		104	7
8	Baseboard Heater	2014	935	171	5	171		171	8
9	Washer-Basement	2014	875	146	5	146		146	9
10	Wireless Internet	2014	1,845	277	5	277		277	10
11	Tile for Room 209 (HCC)	2014	1,786	268	5	268		268	11
12	PC/HCC Wireless w/Mount	2014	710	107	5	107		107	12
13	VESA Mount Compatible PC	2014	885	103	5	103		103	13
14	Central Air (Kitchen)	2014	6,700	782	5	782		782	14
15	PTACS	2014	19,447	1,945	5	1,945		1,945	15
16	Mattress-HCC (Hospital Mattress)	2014	536	54	5	54		54	16
17	Time Clock on Site Lighting	2014	500	42	5	42		42	17
18	Outdoor Horn/Strobe	2014	680	57	5	57		57	18
19	Control Valve Elvator	2014	742	49	5	49		49	19
20	Computer-MDS Coordinator	2014	750	38	5	38		38	20
21	Elevator Equipment	2014	6,005	300	5	300		300	21
22	Astragal Seals Door & Installation	2014	2,100	105	5	105		105	22
23	Web Design	2014	1,222	61	5	61		61	23
24	Steam Table	2014	642	21	5	21		21	24
25	Solid State Starter (Elvator)	2014	2,588		5				25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,811,764	$ 121,689		$ 121,689	$	$ 2,627,440	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: 01/01/2014 Ending: 12/31/2014

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	$ 780,367	$ 40,344	$ 40,344	$		$ 357,196	71
72	Current Year Purchases	19,206	1,032	1,032			1,032	72
73	Fully Depreciated Assets	(11,118)	(3,777)	(3,777)			(11,118)	73
74								74
75	TOTALS	$ 788,455	$ 37,599	$ 37,599	$		$ 347,110	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	$	5	$ 5,512	76
77										77
78										78
79										79
80	TOTALS			$ 11,405	$ 2,281	$ 2,281	$		$ 5,512	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)	$ 4,685,827	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 161,569	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 161,569	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)	$ 2,980,062	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: 01/01/2014 Ending: 12/31/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: 01/01/2014 Ending: 12/31/2014

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.

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2014 (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	$ 175,147	$	1
2	Cash-Patient Deposits	67,495		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at cost)	34,929		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,733		6
7	Other Prepaid Expenses	6,321		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest	24,153		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 313,778	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,705,802		12
13	Land	74,203		13
14	Buildings, at Historical Cost	3,811,763		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	777,475		16
17	Accumulated Depreciation (book methods)	(3,252,695)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,747,376		21
22	Other Long-Term Assets (spe In Perpetual Trust	5,545,061		22
23	Other(specify): R.L. Warner Campus	188,305		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,597,290	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,911,068	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 46,999	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,531		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,416		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)**	$ 221,946	$	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)**	$ 221,946	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,689,122	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,911,068	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,789,960	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,789,960	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(100,838)	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)**	$ (100,838)	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)**	$ 11,689,122	24 *

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 3,027,805	1
2	Discounts and Allowances for all Levels	(180,871)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,846,934	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	27,251	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 27,251	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	109	12
13	Barber and Beauty Care	2,142	13
14	Non-Patient Meals	12,092	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	27,574	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 41,917	23
	D. Non-Operating Revenue		
24	Contributions	12,860	24
25	Interest and Other Investment Income***	572,340	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 585,200	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Beneficial Trust Income on fair value	61,439	28
28a	Gain(Loss)in Fair	5,746	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 67,185	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,568,487	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,114,804	31
32	Health Care	1,408,225	32
33	General Administration	914,516	33
	B. Capital Expense		
34	Ownership	161,569	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	70,211	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,669,325	40
41	**Income before Income Taxes (line 30 minus line 40)****	(100,838)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (100,838)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 115,197	44
45	Private Pay - Net Inpatient Revenue	2,731,737	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)	$ 2,846,934	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: 01/01/2014 Ending: 12/31/2014

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	2,315	2,499	$ 67,504	$ 27.01	1
2	Assistant Director of Nursing	712	752	24,998	33.24	2
3	Registered Nurses	10,373	10,754	278,137	25.86	3
4	Licensed Practical Nurses	10,662	11,122	266,762	23.99	4
5	CNAs & Orderlies	37,249	38,603	438,867	11.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,955	4,996	65,256	13.06	8
9	Activity Director	1,581	1,816	46,685	25.71	9
10	Activity Assistants	3,696	3,873	62,164	16.05	10
11	Social Service Workers	4,192	4,449	57,941	13.02	11
12	Dietician					12
13	Food Service Supervisor	1,868	2,134	37,825	17.72	13
14	Head Cook	7,147	7,402	75,356	10.18	14
15	Cook Helpers/Assistants	15,334	15,826	146,955	9.29	15
16	Dishwashers	2,509	2,636	25,355	9.62	16
17	Maintenance Workers	5,330	5,412	91,182	16.85	17
18	Housekeepers	10,812	11,387	113,430	9.96	18
19	Laundry	5,254	5,870	62,221	10.60	19
20	Administrator	2,308	2,391	95,000	39.73	20
21	Assistant Administrator					21
22	Other Administrative	1,974	2,134	62,000	29.05	22
23	Office Manager	1,971	2,049	33,000	16.11	23
24	Clerical	2,284	2,409	22,935	9.52	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	182	182	2,035	11.18	31
32	Other Health C: MDS Coor	467	467	12,788	27.38	32
33	Other(specify) Driver	1,306	1,370	12,587	9.19	33
34	TOTAL (lines 1 - 33)	134,481	140,533	$ 2,100,983 *	$ 14.95	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		V-B-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	54	1,350	V-B-10-3	38
39	Pharmacist Consultant	42	1,901	V-B-10-3	39
40	Physical Therapy Consultant	Contract	1,445	V-B-10a-3	40
41	Occupational Therapy Consultant	Contract	767	V-B-10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	632	V-B-11-3	44
45	Social Service Consultant	8	632	V-B-12-3	45
46	Other(specify) Chaplain	Contract	2,150	V-B-11-3	46
47	Sunday Clergy		900	V-B-11-3	47
48	MDS Software/Computer Svcs	Contract	7,492	V-B-10-3	48
49	TOTAL (lines 35 - 48)	112	$ 19,094		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: 01/01/2014 Ending: 12/31/2014

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	200
CliftonLarsonAllen	Audit/CPA	15,165
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 15,365

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,566
Unemployment Compensation Insurance	5,193
FICA Taxes	157,510
Employee Health Insurance	271,375
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,698
CPR Training	400
Employee Vaccinations	523
TOTAL (agree to Schedule V, line 22, col.8)	$ 533,265

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	$
Advertising: Employee Recruitment	3,591
Health Care Worker Background Check	553
(Indicate # of checks performed 18)	
Patient Background Checks 31	310
Licenses & Fees	150
Dues	7,123
Non-Allowable Advertising	28,840
Less: Public Relations Expense	(7,038)
Non-allowable advertising	(18,170)
Yellow page advertising	(3,632)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,727

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Soc.Svc.-Res.Care	61
Springfield IL-Admns.Sem.IDPH	293
Seminar Expense	
Seminar-Sprngfield/IDPH	47
Seminar-Admins.Peoria IL	293
Seminar-Admins.Bloomington IL	517
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,211

**See instructions.

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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. **LeadingAge Illinois $3487**

(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. $ **29,358** 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. $ **70,211**
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. $ **14,670**

(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 out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.