FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0018176

Facility Name: Heritage Square

Address: 620 North Ottawa 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 01/01/2017 to 12/31/2017 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)
(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: 01/01/2017 Ending: 12/31/2017

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	365			365	8
9	SNF/PED					9
10	ICF	2,869	5,826		8,695	10
11	ICF/DD					11
12	SC		16,425		16,425	12
13	DD 16 OR LESS					13
14	TOTALS	3,234	22,251		25,485	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.87%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	302,309	27,943	1,800	332,052		332,052		332,052			1
2	Food Purchase		260,228		260,228		260,228	(7,049)	253,179			2
3	Housekeeping	110,940	34,215		145,155		145,155		145,155			3
4	Laundry	66,493	3,830		70,323		70,323		70,323			4
5	Heat and Other Utilities			133,312	133,312		133,312	(18,989)	114,323			5
6	Maintenance	104,245	91,115	8,186	203,546		203,546	(4,965)	198,581			6
7	Other (specify):* Waste Removal			8,186	8,186		8,186		8,186			7
8	**TOTAL General Services**	583,987	417,331	151,484	1,152,802		1,152,802	(31,003)	1,121,799			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,021,367	57,480	19,220	1,098,067		1,098,067	(106)	1,097,961			10
10a	Therapy	137,417		3,465	140,882		140,882		140,882			10a
11	Activities	102,558	9,537	5,004	117,099		117,099	(160)	116,939			11
12	Social Services	56,173	573	1,608	58,354		58,354		58,354			12
13	CNA Training											13
14	Program Transportation		2,193		2,193		2,193		2,193			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,317,515	69,783	29,297	1,416,595		1,416,595	(266)	1,416,329			16
	C. General Administration											
17	Administrative	105,667			105,667		105,667		105,667			17
18	Directors Fees											18
19	Professional Services			15,845	15,845		15,845	(1,000)	14,845			19
20	Dues, Fees, Subscriptions & Promotions			42,872	42,872		42,872	(28,582)	14,290			20
21	Clerical & General Office Expenses	147,016	17,524	9,655	174,195		174,195	(7,660)	166,535			21
22	Employee Benefits & Payroll Taxes			584,800	584,800		584,800		584,800			22
23	Inservice Training & Education			4,055	4,055		4,055		4,055			23
24	Travel and Seminar			2,726	2,726		2,726	(699)	2,027			24
25	Other Admin. Staff Transportation			1,215	1,215		1,215		1,215			25
26	Insurance-Prop.Liab.Malpractice			41,136	41,136		41,136		41,136			26
27	Other (specify):* Sat.TempRestrFund			17,790	17,790		17,790	(17,790)				27
28	**TOTAL General Administration**	252,683	17,524	720,094	990,301		990,301	(55,731)	934,570			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,154,185	504,638	900,875	3,559,698		3,559,698	(87,000)	3,472,698			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: 01/01/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			181,907	181,907		181,907		181,907			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(340,471)	(340,471)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			181,907	181,907		181,907	(340,471)	(158,564)			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			69,905	69,905		69,905		69,905			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			69,905	69,905		69,905		69,905			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,154,185	504,638	1,152,687	3,811,510		3,811,510	(427,471)	3,384,039			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: 01/01/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,049)	V-A-2-7		4
5	Telephone, TV & Radio in Resident Rooms	(18,989)	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	(340,471)	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	(7,660)	V-C-21-7		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	(1,000)	V-C-18-7		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(24,913)	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	(3,669)	V-C-20-7		28
29	Other-Attach Schedule See 5A	(23,720)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (427,471)		$	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))**	$ (427,471)		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: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Repairs to Maint. Equipment	$ (1,453)	V-A-2-7	1
2	Grounds Maint.	(2,780)	V-A-2-7	2
3	Gas,Oil,Grease for Maint.Eqpt	(732)	V-A-2-7	3
4	Piano Tuning	(150)	V-B-3-7	4
5	Name Tag for Actv. Employee	(10)	V-B-3-7	5
6	Reim.Mileage for Soc.Svc.	(29)	V-C-24-7	6
7	Reim.Mileage for Actv	(12)	V-C-24-7	7
8	Reim.for Nursing -Seminar Mileage Diff Nurses	(535)	V-C-24-7	8
9	Reim. For Nursing-Name Tags	(106)	V-B-10-7	9
10	Reim for Administrator-Mileage	(123)	V-C-24-7	10
11	Satisfaction of Temp.Restricted Funds	(17,790)	V-C-27-7	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**	(23,720)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Square **#** 0018176 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,049)	0	0	0	0	0	0	0	0	0	0	(7,049)	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	(18,989)	0	0	0	0	0	0	0	0	0	0	(18,989)	5
6	Maintenance	(4,965)	0	0	0	0	0	0	0	0	0	0	(4,965)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(31,003)	0	0	0	0	0	0	0	0	0	0	(31,003)	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	(106)	0	0	0	0	0	0	0	0	0	0	(106)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(160)	0	0	0	0	0	0	0	0	0	0	(160)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(266)	0	0	0	0	0	0	0	0	0	0	(266)	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	(1,000)	0	0	0	0	0	0	0	0	0	0	(1,000)	19
20	Fees, Subscriptions & Promotions	(28,582)	0	0	0	0	0	0	0	0	0	0	(28,582)	20
21	Clerical & General Office Expenses	(7,660)	0	0	0	0	0	0	0	0	0	0	(7,660)	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	(699)	0	0	0	0	0	0	0	0	0	0	(699)	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):* Sat.TempRestrFu	(17,790)	0	0	0	0	0	0	0	0	0	0	(17,790)	27
28	**TOTAL General Administration**	(55,731)	0	0	0	0	0	0	0	0	0	0	(55,731)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,000)	0	0	0	0	0	0	0	0	0	0	(87,000)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Square **#** 0018176 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(340,471)	0	0	0	0	0	0	0	0	0	0	(340,471)	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**	(340,471)	0	0	0	0	0	0	0	0	0	0	(340,471)	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)**	(427,471)	0	0	0	0	0	0	0	0	0	0	(427,471)	45

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

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: 01/01/2017 Ending: 12/31/2017

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	William Reigle-President	BOD						1
2	Dr. Tim Appenheimer, Vice-President	BOD						2
3	Judge Charles Beckman-Secretary	BOD						3
4	Kenda Bailey-Treasurer	BOD						4
5	Patti Balayti	BOD						5
6	Patrick Jones, Jr.	BOD						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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 2/31/2017

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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

1. Warner Campus - 2 Free standing buildings which equals 4 units.
2. Each of the above 4 units qual 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 Seniors	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: 01/01/2017 Ending: 12/31/2017

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	$		$	$	$ 1,532,081	4
5			1993	1993	1,100,199	27,505	40	27,505		673,872	5
6											6
7											7
8											8
	Improvement Type**										
9	Patio Cover			1980	3,729		20			3,729	9
10	Physical Therapy Room			1985	18,461		18			18,461	10
11	Activity Room LL			1985	3,229		19			3,229	11
12	Soc.Serv.Office			1988	1,319		5			1,319	12
13	Drain Line Trough			1991	2,099		5			2,099	13
14	Storage Shed			1991	1,189		20			1,189	14
15	Fire Alarm Wiring			1991	1,630		5			1,630	15
16	Gutter Downspouts			1991	4,500		15			4,500	16
17	Aiphone Intercom			1992	508		15			508	17
18	Beam Fire Protection			1993	1,380		10			1,380	18
19	Concrete Drive Walks			1993	6,008		15			6,008	19
20	Landscaping (New Wing)			1993	7,749		10			7,749	20
21	Resurface Parking Lot			1993	17,716		15			17,716	21
22	Gutter Downspouts (N. Wing)			1993	3,600		15			3,600	22
23	Concrete Walk & Bench Pad			1994	1,225		20			1,225	23
24	Safety Door Shield			1994	1,250		10			1,250	24
25	Life Safety Door Closer (replace)			1995	4,432		15			4,432	25
26	Patio Sidewalk (replace)			1995	6,507		20			6,363	26
27	Soffit Repair (Vinyl)			1995	4,100		20			4,044	27
28	Walk Drive Approach			1996	3,809		20			3,700	28
29	Storage Shed			1996	707		20			687	29
30	Lighting Replacement (Energy Efficient)			1997	13,031		15			13,031	30
31	Radiant Heat Panels			1998	19,894		10			19,894	31
32	Kitchen Fire System			1998	898	43	20	43		823	32
33	Painting			1999	11,227		5			11,227	33
34	GFI electric update			2000	4,800	228		228		3,908	34
35	New So. Roof			2002	171,935	5,731	30	5,731		87,399	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: 01/01/2017 Ending: 12/31/2017

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	New North Roof	2003	$ 140,137	$ 4,671	30	$ 4,671	$	$ 66,175	37
38	Bathroom Tile	2005	1,500	75	20	75		963	38
39	Replacement of PVC & Clay Tile/Sewer	2005	1,153	38	30	38		481	39
40	Exit/Cylinder Change Room Doors	2005	4,426	221	20	221		2,746	40
41	New Locks for Half of the Resident Rooms	2006	2,897	145	20	145		1,679	41
42	Concrete Work	2006	2,595	173	15	173		1,961	42
43	Asphalt half circle driveway	2006	2,300	153	15	153		1,723	43
44	Automatic door for courtyard	2006	2,665	133	20	133		1,487	44
45	Metal Wall	2007	9,523	476	20	476		5,078	45
46	Commodes	2007	1,366	44	10	44		1,366	46
47	Carpet	2007	3,014	126	10	126		3,013	47
48	Fire Alarm Control Panel	2007	8,000	333	10	333		8,000	48
49	Smoke detectors,horns/strobes,etc	2007	8,763	438	10	438		8,762	49
50	Concrete/Patio	2007	5,860	293	20	293		3,077	50
51	Floor Pedal Sink	2007	380	22	10	22		380	51
52	Actuator (Lifts) - 2	2007	1,072	71	10	71		1,071	52
53	IDPH Fire Improvements	2007	8,755	438	20	438		4,379	53
54	IDPH Fire Improvements-Doors,Frames,hardware	2008	19,090	955	20	955		9,547	54
55	IDPH Fire Improvements-Luse Thermal Firestopping	2008	11,580	579	20	579		5,742	55
56	New Locks for Residents	2008	2,786	139	20	139		1,368	56
57	IDPH Fire Improvement - rolling fire door	2008	10,247	512	20	512		4,951	57
58	Smoke Detector, Door Alarm Lite	2008	1,580	158	10	158		1,541	58
59	Smoke detectors, alarms, etc.	2008	1,300	130	10	130		1,257	59
60	Fire Dampers in Kitchen	2008	1,600	80	20	80		767	60
61	Glue Down Carpet, Cove Base Install	2008	806	81	10	81		775	61
62	ACS Processor (Main Phone System)	2008	1,200	120	10	120		1,130	62
63	New Cabinets - HCC Dining area	2008	563	56	10	56		524	63
64	New Roof	2008	106,223	3,541	30	3,541		33,048	64
65	Sliding Door	2008	5,940	297	20	297		2,772	65
66	New Carpet for Unit A	2008	806	81	10	81		741	66
67	Frames for Doors	2008	2,846	285	10	285		2,587	67
68	Doors & Drywall	2008	9,309	465	20	465		4,226	68
69	Fire Alarm Phase II	2008	3,200	320	10	320		2,880	69
70	TOTAL (lines 4 thru 69)		$ 3,332,694	$ 49,156		$ 49,156	$	$ 2,623,250	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: 01/01/2017 Ending: 12/31/2017

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		$ 3,332,694	$ 49,156		$ 49,156	$	$ 2,623,250	1
2	Creamic tile for 2nd Floor (HCC) Diningroom	2008	1,064	106	10	106		956	2
3	Fabricate & Install Railings on Stairs	2009	3,000	300	10	300		2,675	3
4	Bookkeeper's Door	2009	538	27	20	27		240	4
5	Fire System Update-Phase III	2009	4,553	455	10	455		4,058	5
6	Fire System Update-Phase III	2009	7,320	732	10	732		6,466	6
7	Stainless Steel Bench/Counter/Cabinets	2009	4,506	451	10	451		3,945	7
8	Hollow Metal Door/Kitchen	2009	1,150	115	10	115		978	8
9	Kitchen Renovation	2009	21,628	1,081	20	1,081		9,010	9
10	Fabricate Railing for Court Yard	2009	1,920	192	10	192		1,600	10
11	Cabinets-HCC Dining Room	2009	648	65	10	65		525	11
12	Door-Life Safety Code	2009	4,680	234	20	234		1,872	12
13	Counter Tops for HCC	2010	394	6	7	6		394	13
14	Sidewalk-McKinner to Morgan on Brinton	2010	3,400	227	15	227		1,683	14
15	Beauty Shop Flooring	2011	936	94	10	94		626	15
16	Maintenance Room Steel Door	2011	978	49	20	49		298	16
17	Steel Door/Frame-Soc.Servc.	2012	2,861	286	10	286		1,716	17
18	Shunt Trip Breaker - Elevator	2012	1,983	198	10	198		1,188	18
19	Automatic Sprinkler System	2012	140,225	7,011	20	7,011		41,482	19
20	Circuitry,Switch,&Can Lights-Dining Room	2012	450	60	5	60		450	20
21	Carpet Room 14,19 & 108	2012	3,674	489	5	489		3,674	21
22	Kitchen Serve Button/Breakers	2012	1,050	140	5	140		1,050	22
23	Elevator Phone	2012	99	14	5	14		99	23
24	PTACS	2012	22,296	2,230	10	2,230		11,707	24
25	Stainless Steel Cover for Ice Chest	2013	795	159	5	159		782	25
26	Water Heater	2013	24,114	2,411	10	2,411		11,653	26
27	Washer	2013	7,539	1,508	5	1,508		7,289	27
28	Printer-HCC	2013	771	154	5	154		732	28
29	Mixer Valve for Water Heater	2013	2,075	415	5	415		1,971	29
30	PTACS	2013	14,857	2,971	5	2,971		13,617	30
31	Wireless/Computer for HCC	2013	7,371	1,474	5	1,474		6,756	31
32	Fax Machines	2013	1,000	200	5	200		883	32
33	Heat/Cool Unit	2013	2,750	550	5	550		2,429	33
34	TOTAL (lines 1 thru 33)		$ 3,623,319	$ 73,560		$ 73,560	$	$ 2,766,054	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: 01/01/2017 Ending: 12/31/2017

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		$ 3,623,319	$ 73,560		$ 73,560	$	$ 2,766,054	1
2	Concrete Sidewalk - North End	2013	6,775	1,355	5	1,355		5,985	2
3	Computer & Monitor for Activities/Programs	2013	1,181	236	5	236		1,023	3
4	Computer - Administrator	2013	953	191	5	191		812	4
5	Tile-HCC Room	2013	1,323	265	5	265		1,126	5
6	2 Fire Rings- Per IDPH	2013	403	81	5	81		344	6
7	Carpet - Room 11	2013	885	177	5	177		738	7
8	Generator Circuits	2013	7,984	1,597	5	1,597		6,521	8
9	Electrical Upgrade on HCC	2013	1,500	300	5	300		1,225	9
10	MDS Software-PointClickCare	2013	15,929	3,186	5	3,186		13,010	10
11	Stainless Plates for Dining Room Wall	2013	741	148	5	148		592	11
12	Carpet- Room 5 SC	2013	931	186	5	186		744	12
13	Concentrator	2013	570	114	5	114		456	13
14	Additional Water Heater Costs	2014	1,040	104	10	104		416	14
15	Baseboard Heater	2014	935	187	5	187		732	15
16	Washer	2014	875	175	5	175		671	16
17	Wireless Internet	2014	1,845	369	5	369		1,384	17
18	Tile: Room 209	2014	1,786	357	5	357		1,339	18
19	PC for HCC (Wireless w/Mount)	2014	710	142	5	142		533	19
20	VESA Mount Compatible PC	2014	885	177	5	177		634	20
21	Central Air (Kitchen)	2014	6,700	1,340	5	1,340		4,802	21
22	PTACs (13)	2014	19,447	3,889	5	3,889		13,612	22
23	Mattress - HCC	2014	536	107	5	107		375	23
24	Time Clock on Site Lighting/Wiring	2014	500	100	5	100		342	24
25	Outdoor Horn/Strobe	2014	680	136	5	136		465	25
26	Control Valve-Elevator	2014	742	148	5	148		493	26
27	Computer - MDS Coordinator	2014	750	150	5	150		488	27
28	Elevator Equipment	2014	6,005	1,201	5	1,201		3,903	28
29	Astragal Seals Door & Installation	2014	2,100	420	5	420		1,365	29
30	Web Design	2014	1,222	244	5	244		793	30
31	Steam Table	2014	642	128	5	128		405	31
32	Solid State Starter (Elevator)	2014	2,588	518	5	518		1,554	32
33	Cont'd on Page 12D								33
34	TOTAL (lines 1 thru 33)		$ 3,712,482	$ 91,288		$ 91,288	$	$ 2,832,936	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: 01/01/2017 Ending: 12/31/2017

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		$ 3,712,482	$ 91,288		$ 91,288	$	$ 2,832,936	1
2	2nd Payment on steamer	2015	642	128	5	128		363	2
3	Reclining Tub/HCC	2015	14,440	2,888	5	2,888		7,942	3
4	Mattress-HCC	2015	587	117	5	117		302	4
5	Furnish/Install Magic Force (Door)	2015	2,160	108	5	108		270	5
6	Installed bumper poles	2015	1,200	120	10	120		290	6
7	Seal Coating	2015	3,590	239	15	239		578	7
8	New Door Knobs for Res. Doors	2015	1,578	79	20	79		191	8
9	Plastering Balconey HCC-Final	2015	2,300	153	15	153		370	9
10	Carpet-HCC/tiles-shower	2015	1,569	157	10	157		379	10
11	New Dedicated Circuit for hot water	2015	2,330	466	5	466		1,087	11
12	Installed Embergency Light/batter/Alarm	2015	3,085	617	5	617		1,440	12
13	Automatic Stanley Door	2015	2,160	108	20	108		261	13
14	Heritage Square Sign	2015	12,450	830	15	830		1,798	14
15	Repair HCC Balconey/Poured pad (sign)sidewalk	2015	4,690	313	15	313		652	15
16	Dining Room tile/carpet	2015	66,091	6,609	10	6,609		14,320	16
17	PTACS (11)	2015	16,298	3,260	5	3,260		6,520	17
18	Carpet-SC Hallways	2016	11,660	2,332	5	2,332		2,915	18
19	Refacing Interior Doors	2016	1,632	326	5	326		380	19
20	Nursing Call System	2016	143,580	28,716	5	28,716		28,716	20
21	Tile Flooring - Dining room/Nurses station	2016	18,475	3,695	5	3,695		3,695	21
22	Carpet for rooms 6 & 17	2017	2,003	183	10	183		183	22
23	Carpet for rooms 37 & 38	2017	1,303	239	5	239		239	23
24	HealthCareCenter Privacy Curtains	2017	1,578	145	10	145		145	24
25	Removal of Oak tree and stump	2017	1,200	50	20	50		50	25
26	Flooring for Rooms 218 & 221 in HCC	2017	7,094	591	10	591		591	26
27	Wainscoting with Deco cutouts-Dining room	2017	7,200	540	10	540		540	27
28	Flooring for Room 223 in HCC	2017	2,659	200	10	200		200	28
29	Tile/Vinyl for Room 202 in HCC	2017	3,802	253	10	253		253	29
30	Flooring for Rooms 15,46, & 40 in SC	2017	2,438	142	10	142		142	30
31	Cement parking bumpers	2017	504	15	20	15		15	31
32	Sidewalk/manhole upgrade	2017	975	25	20	25		25	32
33	Cont'd on Page 12E								33
34	TOTAL (lines 1 thru 33)		$ 4,053,755	$ 144,932		$ 144,932	$	$ 2,907,788	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: 01/01/2017 Ending: 12/31/2017

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 12D, Carried Forward		$ 4,053,755	$ 144,932		$ 144,932	$	$ 2,907,788	1
2	Horn Strobes and Pull Station	2017	1,936	97	10	97		97	2
3	Carpet & Tile Room 23	2017	1,312	55	10	55		55	3
4	Water Heater Damper	2017	1,105	46	10	46		46	4
5	Carpet for Room 3	2017	1,198	40	10	40		40	5
6	Surface Fire Rated Vertical Rod	2017	2,614	87	10	87		87	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,061,920	$ 145,257		$ 145,257	$	$ 2,908,113	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: 01/01/2017 Ending: 12/31/2017

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	$ 721,845	$ 35,618	$ 35,618	$		$ 236,226	71
72	Current Year Purchases	8,697	1,032	1,032			1,341	72
73	Fully Depreciated Assets	(4,766)					(4,666)	73
74								74
75	TOTALS	$ 725,776	$ 36,650	$ 36,650	$		$ 232,901	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	$	$	$	5	$ 11,405	76
77										77
78										78
79										79
80	TOTALS			$ 11,405	$	$	$		$ 11,405	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)	$ 4,873,304	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 181,907	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 181,907	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)	$ 3,152,419	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: 01/01/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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.

Facility Name & ID Number Heritage Square **#** 0018176 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017 **(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	$ 209,067	$	1
2	Cash-Patient Deposits	86,761		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at Cost)	48,288		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,811		6
7	Other Prepaid Expenses	8,270		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest	21,592		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 379,789	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,512,044		12
13	Land	74,203		13
14	Buildings, at Historical Cost	4,061,918		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	648,922		16
17	Accumulated Depreciation (book methods)	(3,452,716)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,947,461		21
22	Other Long-Term Assets (spe In Perpetual Trust	5,821,221		22
23	Other(specify): R.L. Warner Campus	133,305		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,746,358	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,126,147	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 45,590	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	225,668		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)**	$ 271,258	$	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)**	$ 271,258	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,854,889	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,126,147	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,315,991	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,315,991	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	538,898	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)**	$ 538,898	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)**	$ 11,854,889	24 *

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 3,516,334	1
2	Discounts and Allowances for all Levels	(271,593)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,244,741	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	18,287	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 18,287	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	112	12
13	Barber and Beauty Care	2,289	13
14	Non-Patient Meals	7,050	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	25,088	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 34,539	23
	D. Non-Operating Revenue		
24	Contributions	58,400	24
25	Interest and Other Investment Income***	340,471	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 398,871	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Beneficial Trust Income on Fair Value	271,355	28
28a	Gain(Loss)on Fair Value	295,615	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 566,970	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,263,408	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,121,799	31
32	Health Care	1,416,329	32
33	General Administration	934,570	33
	B. Capital Expense		
34	Ownership	181,907	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	69,905	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,724,510	40
41	**Income before Income Taxes (line 30 minus line 40)****	538,898	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 538,898	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 289,990	44
45	Private Pay - Net Inpatient Revenue	2,954,751	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)	$ 3,244,741	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: 01/01/2017 Ending: 12/31/2017

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,907	2,056	$ 59,707	$ 29.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,528	11,061	305,824	27.65	3
4	Licensed Practical Nurses	10,845	11,471	296,894	25.88	4
5	CNAs & Orderlies	27,952	28,537	335,111	11.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,999	6,342	98,262	15.49	8
9	Activity Director	3,648	4,050	63,380	15.65	9
10	Activity Assistants	3,664	3,730	38,215	10.25	10
11	Social Service Workers	2,411	3,764	56,386	14.98	11
12	Dietician					12
13	Food Service Supervisor	1,824	2,001	41,329	20.65	13
14	Head Cook	5,179	5,203	55,333	10.63	14
15	Cook Helpers/Assistants	16,316	17,062	166,347	9.75	15
16	Dishwashers	3,533	3,776	39,300	10.41	16
17	Maintenance Workers	5,402	5,626	104,852	18.64	17
18	Housekeepers	10,556	10,933	110,940	10.15	18
19	Laundry	5,129	5,451	66,463	12.19	19
20	Administrator	2,175	2,322	105,667	45.51	20
21	Assistant Administrator					21
22	Other Administrative	1,905	2,081	67,923	32.64	22
23	Office Manager	1,928	2,080	36,030	17.32	23
24	Clerical	2,361	2,481	26,433	10.65	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	436	438	4,415	10.08	31
32	Other Health C: MDS Coordinator	1,982	2,039	58,744	28.81	32
33	Other(specify) Driver	1,551	1,655	16,630	10.05	33
34	TOTAL (lines 1 - 33)	127,231	134,159	$ 2,154,185 *	$ 16.06	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	$ 1,800	V-A-1-3	35
36	Medical Director	Contract	4,950	V-B-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	30	938	V-B-10-3	38
39	Pharmacist Consultant	34	1,665	V-B-10-3	39
40	Physical Therapy Consultant	Contract	2,775	V-B-10a-3	40
41	Occupational Therapy Consultant	Contract	690	V-B-10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,854	V-B-11-3	44
45	Social Service Consultant	24	1,608	V-B-12-3	45
46	Other(specify) Chaplain	Contract	1,775	V-B-11-3	46
47	Sunday Clergy	47	1,225	V-B-12-3	47
48	MDS Software/Computer Svc	Contract	8,206	V-B-10-3	48
49	TOTAL (lines 35 - 48)	159	$ 27,486		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: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonnie K. O'Connell	Administrator	0	$ 104,808
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,808

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	1,000
CliftonLarsonAllen	Audit/CPA	14,845
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 15,845

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,902
Unemployment Compensation Insurance	0
FICA Taxes	159,727
Employee Health Insurance	346,066
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	6,244
Employee Vaccinations	2,861
TOTAL (agree to Schedule V, line 22, col.8)	$ 584,800

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,406
Advertising: Employee Recruitment	4,821
Health Care Worker Background Check	
(Indicate # of checks performed 18)	490
Patient Background Checks 22	240
Licenses & Fees	3,980
Dues	353
Non-Allowable Advertising	28,582
Less: Public Relations Expense	(719)
Non-allowable advertising	(24,194)
Yellow page advertising	(3,669)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,290

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Springfield, IL	457
Peoria, IL	304
Seminar Expense	
INHAA-Springfield-Emerg.Prep	621
INHAA-Peoria-EmergPrem	543
IDPH-Rockford-Survey Updates	102
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,027

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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-$4406**

(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. $ **14,631** 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. $ **69,905**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **7,049**

(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? **Yes**
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: **CliftonLarsonAllenLLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted 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