		FOR BHF USE				

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[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 01/01/2020 to 12/31/2020 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

STATE OF ILLINOIS

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	27	Skilled (SNF)	27	9,882	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	49	Sheltered Care (SC)	49	17,934	5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	7

B. Census-For the entire report period.

	1 Level of Care	2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
		Patient Days by Level of Care and Primary Source of Payment				
8	SNF	1,464			1,464	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	583	5,883		6,466	11
12	SC		14,791		14,791	12
13	DD 16 OR LESS					13
14	TOTALS	2,047	20,674		22,721	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.68%

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)
N/A

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: 12/31/20 Fiscal Year: 12/31/20

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

STATE OF ILLINOIS

Facility Name & ID Number **Heritage Square** **#** **0018176** **Report Period Beginning:** **01/01/2020** **Ending:** **12/31/2020**

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	340,986	31,288	1,800	374,074		374,074		374,074			1
2	Food Purchase		296,250		296,250		296,250	(5,913)	290,337			2
3	Housekeeping	119,347	37,442		156,789		156,789	(8,766)	148,023			3
4	Laundry	81,046	17,562		98,608		98,608		98,608			4
5	Heat and Other Utilities			144,558	144,558		144,558	(25,385)	119,173			5
6	Maintenance	112,504	83,224	18,002	213,730		213,730	(7,788)	205,942			6
7	Other (specify):* Disposal/ShredgSvc			10,852	10,852		10,852	(657)	10,195			7
8	**TOTAL General Services**	653,883	465,766	175,212	1,294,861		1,294,861	(48,509)	1,246,352			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	1,309,763	86,875	13,554	1,410,192		1,410,192	(33,384)	1,376,808			10
10a	Therapy	83,917		3,030	86,947		86,947		86,947			10a
11	Activities	117,206	3,550	2,390	123,146		123,146		123,146			11
12	Social Services	57,349	1,535	1,121	60,005		60,005		60,005			12
13	CNA Training											13
14	Program Transportation		1,703		1,703		1,703	(832)	871			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,568,235	93,663	25,595	1,687,493		1,687,493	(34,216)	1,653,277			16
	C. General Administration											
17	Administrative	112,885			112,885		112,885		112,885			17
18	Directors Fees											18
19	Professional Services			16,790	16,790		16,790		16,790			19
20	Dues, Fees, Subscriptions & Promotions			33,061	33,061		33,061	(24,371)	8,690			20
21	Clerical & General Office Expenses	188,542	27,075	8,752	224,369		224,369	(11,000)	213,369			21
22	Employee Benefits & Payroll Taxes			578,319	578,319		578,319		578,319			22
23	Inservice Training & Education			150	150		150		150			23
24	Travel and Seminar			1,067	1,067		1,067	(101)	966			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,892	74,892		74,892		74,892			26
27	Other (specify):* Satf.TempRestr.Fund			3,000	3,000		3,000	(3,000)				27
28	**TOTAL General Administration**	301,427	27,075	716,031	1,044,533		1,044,533	(38,472)	1,006,061			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,523,545	586,504	916,838	4,026,887		4,026,887	(121,197)	3,905,690			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.

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			157,722	157,722		157,722		157,722			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(674,956)	(674,956)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			157,722	157,722		157,722	(674,956)	(517,234)			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			71,000	71,000		71,000		71,000			42
43	Other (specify):* **Bad Debt**			39,318	39,318		39,318	(39,318)				43
44	**TOTAL Special Cost Centers**			110,318	110,318		110,318	(39,318)	71,000			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,523,545	586,504	1,184,878	4,294,927		4,294,927	(835,471)	3,459,456			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: 01/01/2020 Ending: 12/31/2020

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,913)	V-A-2-7		4
5	Telephone, TV & Radio in Resident Rooms	(25,385)	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	(674,956)	V-A-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	(11,000)	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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,318)	V-E-43-7		24
25	Fund Raising, Advertising and Promotional	(20,234)	V-C-20-7		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,137)	V-C-20-7		28
29	Other-Attach Schedule See pg 5A	(54,528)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (835,471)		$	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))**	$ (835,471)		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

STATE OF ILLINOIS

Heritage Square

ID# 0018176

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Housekeeping-Covid supplies reimbursed	$ (8,766)	V-A-3-7	1
2	Grounds Maintenance	(4,824)	V-A-6-7	2
3	Repairs to Furniture	(180)	V-A-6-7	3
4	Repairs to Maintenance Equipt	(1,284)	V-A-6-7	4
5	Repairs to Motor Vechicle	(1,500)	V-A-6-7	5
6	Shredding service	(657)	V-A-7-7	6
7	Nursing Supplies-Covid supplies reimbursed	(33,384)	V-B-10-7	7
8	Non-Care transportation	(832)	V-B-14-7	8
9	Travel & Seminar-Non Care related	(101)	V-C-24-7	9
10	Satisfaction of Temporary Restricated Funds	(3,000)	V-C-27-7	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**	(54,528)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(5,913)	0	0	0	0	0	0	0	0	0	0	(5,913)	2
3	Housekeeping	(8,766)	0	0	0	0	0	0	0	0	0	0	(8,766)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(25,385)	0	0	0	0	0	0	0	0	0	0	(25,385)	5
6	Maintenance	(7,788)	0	0	0	0	0	0	0	0	0	0	(7,788)	6
7	Other (specify):* Shredding Svc	(657)	0	0	0	0	0	0	0	0	0	0	(657)	7
8	**TOTAL General Services**	(48,509)	0	0	0	0	0	0	0	0	0	0	(48,509)	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	(33,384)	0	0	0	0	0	0	0	0	0	0	(33,384)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(832)	0	0	0	0	0	0	0	0	0	0	(832)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(34,216)	0	0	0	0	0	0	0	0	0	0	(34,216)	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(24,371)	0	0	0	0	0	0	0	0	0	0	(24,371)	20
21	Clerical & General Office Expenses	(11,000)	0	0	0	0	0	0	0	0	0	0	(11,000)	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	(101)	0	0	0	0	0	0	0	0	0	0	(101)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(35,472)	0	0	0	0	0	0	0	0	0	0	(35,472)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(118,197)	0	0	0	0	0	0	0	0	0	0	(118,197)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(674,956)	0	0	0	0	0	0	0	0	0	0	(674,956)	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**	(674,956)	0	0	0	0	0	0	0	0	0	0	(674,956)	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):* **Bad Debt**	(39,318)	0	0	0	0	0	0	0	0	0	0	(39,318)	43
44	**TOTAL Special Cost Centers**	(39,318)	0	0	0	0	0	0	0	0	0	0	(39,318)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(832,471)	0	0	0	0	0	0	0	0	0	0	(832,471)	45

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Patrick Jones, Jr.-Secretary	BOD						3
4	Kenda Bailey-Treasurer	BOD						4
5	Charles Beckman-retired Judge	BOD						5
6	Debra Didier	BOD						6
7	Daniel Kapolnek, Esq.	BOD						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: 01/01/2020 Ending: 12/31/2020

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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: 01/01/2020 Ending: 12/31/2020

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	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: 01/01/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 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 2020 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:		
2015		8
2016		9
2017		10
2018		11
2019		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	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: 01/01/2020 Ending: 12/31/2020

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			5
6											6
7											7
8											8
	Improvement Type**										
9	Patio Cover			1980	3,729		20			3,729	9
10	Activity Room LL			1985	3,229		19			3,229	10
11	Drain Line Trough			1991	2,099		5			2,099	11
12	Wiring of Fire Alarm			1991	1,630		5			1,630	12
13	Gutter Downspouts			1991	4,500		15			4,500	13
14	Aiphone Intercom			1992	508		15			508	14
15	Beam Fire Protection			1993	1,380		10			1,380	15
16	Concrete Drive Walks			1993	6,008		15			6,008	16
17	Trees Shrubs Law			1993	7,749		10			7,749	17
18	Regrade Surface			1993	17,716		15			17,716	18
19	Gutter Downspout N			1993	3,600		15			3,600	19
20	Concrete Walk			1994	1,225		20			1,225	20
21	Safety Door Shield			1994	1,250		10			1,250	21
22	Door Closers Safety			1995	4,432		15			4,432	22
23	Replace Sidewalks			1995	6,507		20			6,507	23
24	Vinyl Soffit			1995	4,100		20			4,100	24
25	Walks Drive Approach			1996	3,809		20			3,809	25
26	EFF Lighting Fixtures			1997	13,031		15			13,031	26
27	Radiant Heat Panels			1998	19,894		10			19,894	27
28	Kitchen Fire System			1998	898		20			898	28
29	GFI Electric Update			2000	4,800	240	20	240		4,616	29
30	New South Roof			2002	171,935	5,731	30	5,731		104,592	30
31	New North Roof			2003	140,137	4,671	30	4,671		80,188	31
32	Bathroom Tile			2005	1,500	75	20	75		1,188	32
33	Replacement of PVC & Clay Tiles			2005	1,153	38	30	38		595	33
34	Exit/Cylinder Change Room Doors			2005	4,426	221	20	221		3,409	34
35	New Locks for half of the Resident Rooms			2006	2,897	145	20	145		2,114	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: 01/01/2020 Ending: 12/31/2020

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	Concrete Work	2006	$ 2,595	$ 173	15	$ 173	$	$ 2,480	37
38	Automatic Door for Courtyard	2006	2,665	133	20	133		1,886	38
39	Asphalt Half Circle driveway	2006	2,300	153	15	153		2,182	39
40	Metal Wall	2007	9,523	476	20	476		6,506	40
41	Carpet	2007	3,014		10			3,014	41
42	Fire Alarm Control Panel	2007	8,000		10			8,000	42
43	Smoke detectors horns/strobes	2007	8,763		10			8,763	43
44	Concrete Patio	2007	5,860		10			5,860	44
45	Actuator (Lifts) - 2	2007	1,072		10			1,072	45
46	IDPH Fire Improvements	2007	8,755	438	20	438		5,693	46
47	IDPH Fire Improvements-Door Frames	2008	19,090	955	20	955		12,412	47
48	IDPH Fire Improvements-Luse Thermal	2008	11,580	579	20	579		7,479	48
49	New Locks for Residents	2008	2,786	139	20	139		1,785	49
50	Smoke Detecto Door Alarm Lite	2008	1,580		10			1,580	50
51	IDPH Fire Improvement-Rolling Fire	2008	10,247	512	20	512		6,487	51
52	Smoke Dectectors alarms	2008	1,300		10			1,300	52
53	Fire Dampers in Kitchen	2008	1,600	80	20	80		1,007	53
54	Glue down carpet cove base	2008	806		10			806	54
55	New Roof	2008	106,223	3,541	30	3,541		43,671	55
56	Sliding Door	2008	5,940	297	10	297		3,663	56
57	New Carpet for Unit A	2008	806		10			806	57
58	Frames for Doors	2008	2,846		10			2,846	58
59	Doors & Drywall	2008	9,309	465	20	465		5,621	59
60	Fire Alarm Phase II	2008	3,200		10			3,200	60
61	Creamic Tile for 2nd Floor Dining RM	2008	1,064		10			1,064	61
62	Fabricate & Install Railings on Stairways	2009	3,000		10			3,000	62
63	Fire System Update-Phase III	2009	4,553		10			4,553	63
64	Fire System Update-Phase III	2009	7,320		10			7,320	64
65	Stainless Sttel Bench/Counter/Cabinets	2009	4,506		10			4,506	65
66	Hollow Metal Door/Kitchen	2009	1,150		10			1,150	66
67	Kitchen Renovation	2009	21,628	1,081	20	1,081		12,253	67
68	Door-Life Safety Code	2009	4,680	234	20	234		2,574	68
69	See Page 12B								69
70	TOTAL (lines 4 thru 69)		$ 3,344,183	$ 47,882		$ 47,882	$	$ 2,010,616	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: 01/01/2020 Ending: 12/31/2020

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		$ 3,344,183	$ 47,882		$ 47,882	$	$ 2,010,616	1
2	Sidewalk-McKinney to Morgan on Brinton	2010	3,400	227	15	227		2,363	2
3	Steel Door/Frame-Soc.Serv.	2012	2,861	286	10	286		2,574	3
4	Automatic Sprinkler System	2012	140,225	7,011	20	7,011		62,515	4
5	Carpet-rooms 14,19 & 108	2012	3,674		5			3,674	5
6	PTACS	2012	22,296	2,229	10	2,229		18,396	6
7	Water Heater	2013	24,114	2,411	10	2,411		18,886	7
8	Washer	2013	7,539		5			7,539	8
9	Mixer Valve for Water Heater	2013	2,075		5			2,075	9
10	Wireless/Computers for HCC	2013	7,371		5			7,371	10
11	Heat/Cool Unit	2013	2,750		5			2,750	11
12	Concrete Sidewalk-North End	2013	6,775		5			6,775	12
13	Computer/Monitor for Activities/Programs	2013	1,181		5			1,181	13
14	Computer Administrator	2013	953		5			953	14
15	Tile-HCC Room	2013	1,323		5			1,323	15
16	Carpet Room - 11	2013	885		5			885	16
17	Generator Circuits	2013	7,984		5			7,984	17
18	MDS Software-PointClickCare	2013	15,929		5			15,929	18
19	Wireless Internet	2014	1,845		5			1,845	19
20	PC for HCC (Wireless w/Mount)	2014	710		5			710	20
21	VESA Mount Compatible PC	2014	885		5			885	21
22	Central Air (Kitchen)	2014	6,700		5			6,700	22
23	PTACs (13)	2014	19,447		5			19,447	23
24	Computer-MDS Coordinator	2014	750		5			750	24
25	Elevator Equipment	2014	6,005		5			6,005	25
26	Web Design	2014	1,222		5			1,222	26
27	Solid State Starter (Elevator)	2014	2,588		5			2,588	27
28	Reclining Tub/HCC	2015	14,440	722	5	722		14,440	28
29	Furnish/Install Magic Force (Door)	2015	2,160	108	20	108		594	29
30	Automatic Stanley Door	2015	2,160	108	20	108		585	30
31	Installed Emergency Light/Battery	2015	3,085	41	5	41		3,085	31
32	Heritage Square Sign	2015	12,450	830	15	830		4,288	32
33	See page 12C								33
34	TOTAL (lines 1 thru 33)		$ 3,669,965	$ 61,855		$ 61,855	$	$ 2,236,933	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: 01/01/2020 Ending: 12/31/2020

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		$ 3,669,965	$ 61,855		$ 61,855	$	$ 2,236,933	1
2	Dining Room Tile/Carpet	2015	66,091	6,609	10	6,609		34,147	2
3	Repair HCC Balconey poured pad	2015	4,690	313	15	313		1,591	3
4	PTACs (11)	2015	16,298	3,258	5	3,258		16,298	4
5	Carpet	2016	11,660	2,332	5	2,332		9,911	5
6	Refacing Interior Doors	2016	1,632	326	5	326		1,358	6
7	Nursing Call System	2016	143,580	28,716	5	28,716		114,864	7
8	Tile Flooring-Nurses Station/Dining Room	2016	18,475	3,695	5	3,695		14,780	8
9	Carpet Rooms 6 & 17	2017	2,003	200	10	200		783	9
10	Carpets Romms 37 & 38	2017	1,303	261	5	261		1,021	10
11	HCC Privacy Curtains	2017	1,578	158	10	158		619	11
12	Removal of Oak Tree	2017	1,200	60	20	60		230	12
13	Flooring-Rooms 218 & 221	2017	7,094	709	10	709		2,718	13
14	Wainscoting with Deco cutouts	2017	7,200	720	10	720		2,700	14
15	Flooring-Room 223	2017	2,659	266	10	266		998	15
16	Tile/Vinyl for Room 202	2017	3,802	380	10	380		1,393	16
17	Flooring-Rooms 15,46 & 40	2017	2,438	244	10	244		874	17
18	Cement parking bumpers	2017	504	25	20	25		90	18
19	Sidewalk/manhole upgrade	2017	975	49	20	49		172	19
20	Horn Strobes and Pull Station	2017	1,936	194	10	194		678	20
21	Carpet/Tile-Room 23	2017	1,312	131	10	131		448	21
22	Carpet for Room 3	2017	1,198	120	10	120		400	22
23	Surface Fire Rated Vertical Rod	2017	2,614	261	10	261		870	23
24	Tiling & Floor Covering - Room 20	2018	4,071	407	10	407		1,051	24
25	AHU/AC for Dining Room	2018	5,950	595	10	595		1,537	25
26	Carpet-Room 31	2018	956	96	10	96		240	26
27	Floor Scrubber	2018	2,348	469	5	469		1,135	27
28	Carpet-Room 39	2018	764	76	10	76		171	28
29	Carpet-Room 18	2018	724	72	10	72		162	29
30	Carpet-Room 33 & 36	2018	1,361	136	10	136		295	30
31	Carpet-Room 13	2018	664	66	10	66		138	31
32	Bathtub-PT Room	2018	13,628	1,363	10	1,363		2,726	32
33	See page 12D								33
34	TOTAL (lines 1 thru 33)		$ 4,000,673	$ 114,162		$ 114,162	$	$ 2,451,331	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: 01/01/2020 Ending: 12/31/2020

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		$ 4,000,673	$ 114,162		$ 114,162	$	$ 2,451,331	1
2	PT Room - Tiling around Bathtub	2018	5,949	595	10	595		1,190	2
3	2 HCC Laptops for Medical Records	2019	1,116	205	5	205		427	3
4	New Computers for Dietary w/Office 2019	2019	850	170	5	170		326	4
5	Dir. Of Nursing-Computer	2019	850	170	5	170		326	5
6	Nurse Call system-Software Update	2019	4,980	913	5	913		1,909	6
7	Carpet-Room 27	2019	633	106	5	106		232	7
8	PTAC (4)	2019	1,570	262	5	262		575	8
9	Lift w/Scale	2019	4,382	584	5	584		1,460	9
10	Computer/Software-Bookkeeper	2019	1,145	133	5	133		362	10
11	Physical Therapy Room-Painting	2019	7,063	824	5	824		2,236	11
12	ASUS VivoBook2-(Req.Electronic Med. Records)	2019	1,330	111	5	111		377	12
13	New Alarm System-SC	2019	15,780	1,315	5	1,315		4,471	13
14	2nd payment-eMar/Pharmacy	2019	2,400	200	5	200		680	14
15	New Flooring for quest diningroom	2019	4,065	203	5	203		1,016	15
16	Security Eqpt. For Building	2019	9,012	451	5	451		2,253	16
17	Gov't approved Tar Sealer, parking lot	2019	2,836	32	15	32		221	17
18	Wireless Upgrade for EMR	2019	1,300	43	5	43		303	18
19	Install New Dryer	2019	418	7	10	7		49	19
20	Hopper Room	2020	2,359	216	10	216		216	20
21	Shower Hall	2020	1,090	100	10	100		100	21
22	Security System	2020	7,438	1,364	5	1,364		1,364	22
23	Carpet-Room 14	2020	1,252	104	10	104		104	23
24	Handrail by Garage	2020	2,840	212	10	212		212	24
25	Stainless Count Top/Cover Wood	2020	1,999	150	10	150		150	25
26	SC Treatment Room-Upgrade Tile	2020	1,803	90	10	90		90	26
27	50% on Fire Door	2020	3,419	342	5	342		342	27
28	Fire Door (2nd payment)	2020	3,419	285	5	285		285	28
29	Flooring Room 204	2020	2,900	121	10	121		121	29
30	Rollup Generator Quick Connect	2020	12,045	803	5	803		803	30
31	Upgraded Telligence (Nurse Call System)	2020	2,400	160	5	160		160	31
32									32
33	See page 12E								33
34	TOTAL (lines 1 thru 33)		$ 4,109,316	$ 124,433		$ 124,433	$	$ 2,473,691	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: 01/01/2020 Ending: 12/31/2020

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	$ 687,109	$ 24,067	$ 24,067	$		$ 134,589	71
72	Current Year Purchases	102,035	9,222	9,222			9,222	72
73	Fully Depreciated Assets	(48,584)					(48,584)	73
74								74
75	TOTALS	$ 740,560	$ 33,289	$ 33,289	$		$ 95,227	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 Buck LeSabre	2012	$ 11,405	$	$	$		$ 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)	$ 4,935,484	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 157,722	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 157,722	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)	$ 2,580,323	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: 01/01/2020 Ending: 12/31/2020

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

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: *

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: 01/01/2020 Ending: 12/31/2020

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 476,496	$	1
2	Cash-Patient Deposits	104,432		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at Cost)	75,525		4
5	Short-Term Investments			5
6	Prepaid Insurance	20,442		6
7	Other Prepaid Expenses	10,234		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 687,129	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,570,270		12
13	Land	74,203		13
14	Buildings, at Historical Cost	4,149,929		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	636,002		16
17	Accumulated Depreciation (book methods)	(3,786,585)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,208,410		21
22	Other Long-Term Assets (spe In Perpetual Trust	6,170,394		22
23	Other(specify): R.L. Warner Campus	118,305		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,140,928	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,828,057	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 74,852	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	177,778		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	Refundable grant advance	499,800		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 752,430	$	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)**	$ 752,430	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 12,075,627	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,828,057	$	48

*(See instructions.)

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,925,072	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,925,072	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	150,555	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)**	$ 150,555	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)**	$ 12,075,627	24 *

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 3,961,950	1
2	Discounts and Allowances for all Levels	(762,132)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,199,818	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	13,447	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 13,447	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	44	12
13	Barber and Beauty Care	420	13
14	Non-Patient Meals	1,095	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	33,193	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 34,752	23
	D. Non-Operating Revenue		
24	Contributions	331,182	24
25	Interest and Other Investment Income***	674,956	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,006,138	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Beneficial Trust Income on Fair Value	191,327	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 191,327	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,445,482	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,294,861	31
32	Health Care	1,687,493	32
33	General Administration	1,044,533	33
	B. Capital Expense		
34	Ownership	157,722	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	71,000	36
	D. Other Expenses (specify):		
37	Bad Debt Write off	39,318	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,294,927	40
41	**Income before Income Taxes (line 30 minus line 40)****	150,555	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 150,555	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 258,472	44
45	Private Pay - Net Inpatient Revenue	2,941,346	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)	$ 3,199,818	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: 01/01/2020 Ending: 12/31/2020

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	1,868	1,908	$ 52,212	$ 27.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,828	8,081	257,211	31.83	3
4	Licensed Practical Nurses	14,021	14,943	416,527	27.87	4
5	CNAs & Orderlies	32,869	34,237	506,430	14.79	5
6	CNA Trainees	265	265	3,482	13.14	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,297	4,610	83,917	18.20	8
9	Activity Director	3,835	4,160	69,242	16.64	9
10	Activity Assistants	3,652	3,943	47,964	12.16	10
11	Social Service Workers	2,972	3,065	57,349	18.71	11
12	Dietician					12
13	Food Service Supervisor	1,838	2,080	45,517	21.88	13
14	Head Cook	4,965	5,412	61,224	11.31	14
15	Cook Helpers/Assistants	17,487	18,332	200,163	10.92	15
16	Dishwashers	2,618	2,935	34,082	11.61	16
17	Maintenance Workers	4,484	5,735	112,504	19.62	17
18	Housekeepers	10,228	10,953	119,347	10.90	18
19	Laundry	5,531	5,907	81,046	13.72	19
20	Administrator	2,364	2,492	112,885	45.30	20
21	Assistant Administrator					21
22	Other Administrative	3,555	3,761	102,727	27.31	22
23	Office Manager	1,764	2,080	37,783	18.16	23
24	Clerical	2,421	2,503	27,719	11.07	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	42	42	572	13.62	31
32	Other Health Care(specify)	2,099	2,228	73,329	32.91	32
33	Other(specify)	1,364	1,464	20,313	13.88	33
34	TOTAL (lines 1 - 33)	132,367	141,136	$ 2,523,545 *	$ 17.88	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	5,500	V-B-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	37	925	V-B-10-3	38
39	Pharmacist Consultant	51	2,295	V-B-10-3	39
40	Physical Therapy Consultant	99	2,970	V-B-10a-3	40
41	Occupational Therapy Consultant	2	60	V-B-10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Contract	2,140	V-B-11-3	44
45	Social Service Consultant	Contract	1,121	V-B-12-3	45
46	Other(specify) Chaplain	Contract	25	V-B-11-3	46
47	Sunday Clergy		225	V-B-11-3	47
48	MDS Software/Computer Svc	Contract	10,334	V-B-10-3	48
49	TOTAL (lines 35 - 48)	189	$ 27,395		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: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bonnie K. O'Connell	Administrator	0	$ 112,885
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 112,885

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
Sikich, LLP	Audit/CPA	$ 16,000
CliftonLarsonAllen	CPA	790
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 16,790

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,037
Unemployment Compensation Insurance	199
FICA Taxes	191,322
Employee Health Insurance	331,348
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,370
Employee Vaccinations	4,043
TOTAL (agree to Schedule V, line 22, col.8)	$ 578,319

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	1,497
Health Care Worker Background Check (Indicate # of checks performed 18)	628
Patient Background Checks 6	60
Fees	3,061
Leading Age	3,444
Non-Allowable Adertising	24,371
Less: Public Relations Expense	(2,783)
Non-allowable advertising	(17,451)
Yellow page advertising	(4,137)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,690

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Davenport, IA	153
In-State Travel	
Seminar Expense	
Region III OWLAPA	50
2020 Virtual Confr-INHA	300
Food Safety/Handling-Virtual	463
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 966

**See instructions.

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. **Leading Age - $3444**

(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? **n/a**

(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? **n/a**

(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. $ **18,954** 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. **n/a**

(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.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **71,000**
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. $ **5,913**

(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: **Sikich 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.