		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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 Avenue (Number) Dixon (City) 61021 (Zip Code)

County: Lee

Telephone Number: 815-288-2251 **Fax #** 815-288-6821

HFS ID Number: 36-6054357-001

Date of Initial License for Current Owners: 11/08/74

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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/08 to 12/31/08 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Bonnie K. O'Connell
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) N/A
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Julia O'Farrell,Bookkeeper
Bonnie O'Connell, Administrator
Telephone Number: 815-288-2251
Email Address:

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: 01/01/08 Ending: 12/31/08

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	675	8,068		8,743	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		15,001		15,001	12
13	DD 16 OR LESS					13
14	TOTALS	675	23,069		23,744	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.36%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
0

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/07/1974

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	242,249	26,700	1,800	270,749		270,749	(8,671)	262,078			1
2	Food Purchase		229,191		229,191		229,191	(10,350)	218,841			2
3	Housekeeping	109,258	14,532	724	124,514		124,514	(6,050)	118,464			3
4	Laundry	25,718	7,523		33,241		33,241	(784)	32,457			4
5	Heat and Other Utilities			129,653	129,653		129,653		129,653			5
6	Maintenance	97,485	42,979	958	141,422		141,422	(5,079)	136,343			6
7	Other (specify):* Waste Removal			3,219	3,219		3,219		3,219			7
8	TOTAL General Services	474,710	320,925	136,354	931,989		931,989	(30,934)	901,056			8
	B. Health Care and Programs											
9	Medical Director			2,050	2,050		2,050		2,050			9
10	Nursing and Medical Records	860,057	34,626	970	895,653		895,653	(38,241)	857,413			10
10a	Therapy	50,972		2,370	53,342		53,342	(3,296)	50,046			10a
11	Activities	82,331	4,719	3,257	90,307		90,307	(3,991)	86,316			11
12	Social Services	53,927	229	103	54,259		54,259	(3,218)	51,041			12
13	CNA Training											13
14	Program Transportation		3,115	1,499	4,614		4,614	(499)	4,115			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,047,287	42,689	10,249	1,100,225		1,100,225	(49,245)	1,050,980			16
	C. General Administration											
17	Administrative	76,254			76,254		76,254		76,254			17
18	Directors Fees											18
19	Professional Services			15,325	15,325		15,325	(734)	14,591			19
20	Dues, Fees, Subscriptions & Promotions			42,302	42,302		42,302	(34,859)	7,443			20
21	Clerical & General Office Expenses	105,795	11,482	33,537	150,814		150,814	(25,601)	125,213			21
22	Employee Benefits & Payroll Taxes			361,508	361,508		361,508		361,508			22
23	Inservice Training & Education			159	159		159		159			23
24	Travel and Seminar			2,401	2,401		2,401	(411)	1,990			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			84,645	84,645		84,645		84,645			26
27	Other (specify):*											27
28	TOTAL General Administration	182,049	11,482	539,877	733,408		733,408	(61,605)	671,803			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,704,046	375,096	686,480	2,765,622		2,765,622	(141,784)	2,623,838			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: 01/01/08 Ending: 12/31/08

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			133,115	133,115		133,115	133,115	266,230			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70	70		70	(355,341)	(355,271)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			133,185	133,185		133,185	(222,226)	(89,041)			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			14,866	14,866		14,866	14,866	29,732			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			14,866	14,866		14,866	14,866	29,732			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,704,046	375,096	834,531	2,913,673		2,913,673	(349,144)	2,564,529			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: 01/01/08 Ending: 12/31/08

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	10,350	V-A-2-7		4
5	Telephone, TV & Radio in Resident Rooms	13,361	-C-21-7		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	355,341	-D-32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	790	-C-21-7		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	734	-C-19-7		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	31,201	-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	3,658	-C-20-7		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 415,435		$	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))**	$ 415,435		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: 01/01/08

Ending: 12/31/08

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Seminar & Travel-Nursing	$ 499	V-B-14-7	1
2	Seminar & Travel- Admn	411	V-C-24-7	2
3	Accr.Vac.from 07-Dietary	8,671	V-A-1-7	3
4	Accr.Vac.from 07-Housekeeping	6,050	V-A-3-7	4
5	Accr.Vac.from 07-Laundry	784	V-A-4-7	5
6	Accr.Vac.from 07-Maintenance	5,079	V-A-6-7	6
7	Accr.Vac.from 07-Nursing	38,241	V-B-10-7	7
8	Accr.Vac.from 07-Therapy	3,296	V-B-10a-7	8
9	Accr.Vac.from 07-Activities	3,991	V-B-11-7	9
10	Accr.Vac.from 07-Social Services	3,218	V-B-12-7	10
11	Accr.Vac.from 07-Clerical/Administrative	11,450	V-C-21-7	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	81,690		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	8,671	0	0	0	0	0	0	0	0	0	0	8,671	1
2	Food Purchase	10,350	0	0	0	0	0	0	0	0	0	0	10,350	2
3	Housekeeping	6,050	0	0	0	0	0	0	0	0	0	0	6,050	3
4	Laundry	784	0	0	0	0	0	0	0	0	0	0	784	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	5,079	0	0	0	0	0	0	0	0	0	0	5,079	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	30,934	0	0	0	0	0	0	0	0	0	0	30,934	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	38,241	0	0	0	0	0	0	0	0	0	0	38,241	10
10a	Therapy	3,296	0	0	0	0	0	0	0	0	0	0	3,296	10a
11	Activities	3,991	0	0	0	0	0	0	0	0	0	0	3,991	11
12	Social Services	3,218	0	0	0	0	0	0	0	0	0	0	3,218	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	499	0	0	0	0	0	0	0	0	0	0	499	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	49,245	0	0	0	0	0	0	0	0	0	0	49,245	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	734	0	0	0	0	0	0	0	0	0	0	734	19
20	Fees, Subscriptions & Promotions	34,859	0	0	0	0	0	0	0	0	0	0	34,859	20
21	Clerical & General Office Expenses	25,601	0	0	0	0	0	0	0	0	0	0	25,601	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	411	0	0	0	0	0	0	0	0	0	0	411	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**	61,605	0	0	0	0	0	0	0	0	0	0	61,605	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	141,784	0	0	0	0	0	0	0	0	0	0	141,784	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	133,115	0	0	0	0	0	0	0	0	0	0	133,115	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(355,271)	0	0	0	0	0	0	0	0	0	0	(355,271)	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	(222,156)	0	0	0	0	0	0	0	0	0	0	(222,156)	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	14,866	0	0	0	0	0	0	0	0	0	0	14,866	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	14,866	0	0	0	0	0	0	0	0	0	0	14,866	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(65,506)	0	0	0	0	0	0	0	0	0	0	(65,506)	45

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/08 Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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	Annuity Interest		X	Annuity	Annual		$	$			$ 70	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 70	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 70	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: 01/01/08 Ending: 12/31/08

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 2007 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 2008 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:		
2003		8
2004		9
2005		10
2006		11
2007		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 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 2007 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 2007.

	(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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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: 01/01/08 Ending: 12/31/08

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

1. Warner Campus - 2 Free Standing Buildings which equals 4 units.
2. Each of the above 7 units equal 1160 Sq.Ft. each, plus garage.
(Above information taken from architect prints.)

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Home for Aged	97,046	1963	$ 42,888	1
2				31,315	2
3	TOTALS	97,046		$ 74,203	3

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1974	1974	$ 1,532,081	$ 38,302	40	$ 38,302	$	$ 1,311,941	4
5			1993	1993	1,100,199	27,505	40	27,505		426,327	5
6											6
7											7
8											8
	Improvement Type**										
9	Outdoor Lights			1977	696		20			696	9
10	Patio Cover			1980	3,729		10			3,729	10
11	Storeroom Sprinkler			1981	1,309		20			1,309	11
12	P.T. & Rehab.Rm			1985	18,461		18			18,461	12
13	L.L.Act.(ReassignedB.SP.)			1985	3,229		19			3,229	13
14	Soc.Service Office			1988	1,319	20	20	20		1,319	14
15	Roof (HCCWin)			1988	5,940		15			5,940	15
16	Parking Lot			1989	11,398	542	20	542		10,914	16
17	Gutter & Downspouts (S.Wing)			1991	4,500		15			4,500	17
18	Plumbing Replacement			1991	2,099	100	20	100		1,800	18
19	Storage Shed			1991	1,189	57	20	57		1,018	19
20	Fire Alarm Improvements			1991	1,630	78	20	78		1,400	20
21	Intercom Improvement			1992	508		15			508	21
22	Fire Protection Beams			1993	1,380		10			1,380	22
23	Concrete Walk & Driveway			1993	6,008	258	15	258		6,008	23
24	Landscaping (New Wing)			1993	7,749		10			7,749	24
25	Resurface Parking Lot			1993	17,716	1,102	15	1,102		17,716	25
26	Gutter & Downspouts (N.Wing)			1993	3,600	216	15	216		3,600	26
27	Heating (HCC Floor)			1994	3,966		10			3,966	27
28	Elevator Safety Shield			1994	1,250		10			1,250	28
29	Concrete Walk & Bench Pad			1994	1,225	58	20	58		896	29
30	Painting Facia of Building			1994	1,955		5			1,955	30
31	Life Safety Door Closer (replace)			1995	4,432	276	15	276		3,845	31
32	Patio Sidewalk (Replace)			1995	6,507	309	20	309		4,277	32
33	Soffit Repair (Vinyl)			1995	4,100	194	20	194		2,696	33
34	Attic Ventilation (S.Wing in SC)			1996	11,600	551	20	551		7,047	34
35	Exterior Walks & Drive			1996	3,809	181	20	181		2,313	35
36	(Cont'd on page 12-4)										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: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	N.E.Outdoor Storage shed	1996	$ 707	$ 33	20	$ 33	$	$ 428	37
38	Lighting Replacement (Energy Efficient)	1997	13,031	811	15	811		9,586	38
39	Radiant Heat Panels (S.C.)	1998	19,894	1,791	10	1,791		19,661	39
40	Bed Runner Guards (HCC)	1998	765		5			765	40
41	Kitchen Fire System	1998	898	43	20	43		438	41
42	8 Attice Exhaust Fans (S.C.)	1998	6,356	302	20	302		3,173	42
43	Painting	1999	11,227		5			11,227	43
44	Deposit Bldg.Extens.	2000	2,346						44
45	GFI Electrical Upgrades	2000	4,800	228	20	228		1,856	45
46	Paint Halls & Doors	2001	5,970		5			5,970	46
47	New South Roof	2002	171,935	5,731	30	5,731		35,820	47
48	New Roof	2003	140,137	4,672	30	4,672		24,135	48
49	Replacement of Clay Title & Pvc	2005	1,153	39	30	39		138	49
50	Repair & Replace No.Driveway	2005	9,330	622	15	622		1,918	50
51	Bathroom Tile	2005	1,500	75	20	75		288	51
52	Repair & Waterproof Balcony	2005	6,500	325	20	325		1,110	52
53	Exit/Cylinder Change Room Doors	2005	4,426	221	20	221		756	53
54	Prime & Paint Handrail on Bldg.	2005	3,360	336	10	336		1,092	54
55	New Locks on half the Resident Doors	2006	2,897	145	20	145		374	55
56	Carpet for Office & Entrance	2006	7,307	1,461	5	1,461		3,775	56
57	Concrete Work	2006	2,595	173	15	173		404	57
58	Automatic Door for Courtyard	2006	2,665	134	20	134		289	58
59	Asphalt Half circle driveway	2006	2,300	153	15	153		345	59
60	Carpet for Residents/Hallways	2007	3,014	301	10	301		477	60
61	Metal Wall	2007	9,523	477	20	477		794	61
62	Commodes	2007	1,366	137	10	137		228	62
63	Landscaping/Flowers	2007	250	83	3	83		132	63
64	Fire Alarm Control Panel	2007	8,000	800	10	800		1,267	64
65	Smoke Detectors/horns/strobes	2007	8,763	876	10	876		1,314	65
66	Concrete Patio	2007	5,860	293	20	293		440	66
67	Wall Station Dukane 4A1225	2007	723	145	5	145		205	67
68	Floor Pedal Sink	2007	380	38	10	38		54	68
69	Cont'd on Page 12B								69
70	TOTAL (lines 4 thru 69)		$ 3,223,562	$ 90,194		$ 90,194	$	$ 1,986,248	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: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 3,223,562	$ 90,194		$ 90,194	$	$ 1,986,248	1
2	Actuator (Lifts)-2	2007	1,072	107	10	107		143	2
3	IDPH Fire Imprv.Caulking/FireAlarmPanel	2007	8,755	438	20	438		438	3
4	IDPH-Luse Thermal/Doors,Frames,hardware	2008	19,090	954	20	954		954	4
5	IDPH-Luse Thermal/Masonry/Painting	2008	11,580	531	20	531		531	5
6	IDPH-RollingFireDoor,Luse Thermal	2008	10,247	342	20	342		342	6
7	Door Locks-Resident Rooms	2008	2,786	116	20	116		116	7
8	Creamic tile for 2nd Flr Dining	2008	1,064		10				8
9	New Carpet for Unit A	2008	806	13	10	13		13	9
10	New Carpet	2008	1,511	113	10	113		113	10
11	Cove Base Installation-Carpet/Gluedown	2008	806	47	10	47		47	11
12	ACS Processor (Main Phone System)	2008	1,200	50	10	50		50	12
13	New Cabinets-HCC Dining Area	2008	563	19	10	19		19	13
14	Fire Dampers in Kitchen	2008	1,600	47	20	47		47	14
15	SmokeDect.,Alarms to Fire Panel	2008	1,300	87	10	87		87	15
16	Frames for Doors	2008	2,846	24	10	24		24	16
17	Doors & Drywall	2008	9,309	39	20	39		39	17
18	Sliding Front Door	2008	5,940	99	20	99		99	18
19	Smoke Detector,Door Alarm Lite	2008	1,580	119	10	119		119	19
20	Fire Alarm Phase II	2008	3,200		10				20
21	New Roof	2008	106,223	1,180	30	1,180		1,180	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,415,039	$ 94,519		$ 94,519	$	$ 1,990,609	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: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 596,845	$ 30,741	$ 30,741	$		$ 361,995	71
72	Current Year Purchases	86,071	4,603	4,603			4,603	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 682,916	$ 35,344	$ 35,344	$		$ 366,598	75

D. Vehicle Depreciation (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	2001 Grand Marquis Mercury	2005	$ 13,011	$ 3,252	$ 3,252	$	4	$ 10,029	76
77										77
78										78
79										79
80	TOTALS			$ 13,011	$ 3,252	$ 3,252	$		$ 10,029	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)	$ 4,185,169	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 133,115	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 133,115	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)	$ 2,367,236	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: 01/01/08 Ending: 12/31/08

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.	/2009	$
13.	/2010	$
14.	/2011	$

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: 01/01/08 Ending: 12/31/08

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)	$			

(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.

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	

(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: 01/01/08 Ending: 12/31/08

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (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	$ 2,384,550	$	1
2	Cash-Patient Deposits	96,297		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at Cost)	30,320		4
5	Short-Term Investments			5
6	Prepaid Insurance	18,943		6
7	Other Prepaid Expenses	3,907		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest	6,294		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,540,311	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	138,470		11
12	Long-Term Investments	1,151,221		12
13	Land	74,203		13
14	Buildings, at Historical Cost	3,415,042		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	680,451		16
17	Accumulated Depreciation (book methods)	(2,464,493)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	234,987		21
22	Other Long-Term Assets (spe Int.Prepetual Trust	4,540,355		22
23	Other(specify): R.L. Warner Campus	188,305		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,958,541	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,498,852	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 46,892	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	178,676		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)**	$ 225,568	$	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	Gift Annuity	1,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 226,568	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 10,272,284	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,498,852	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,125,665	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,125,665	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,853,382)	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)**	$ (1,853,382)	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)**	$ 10,272,284	24 *

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

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,474,533	1
2	Discounts and Allowances for all Levels	(86,369)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,388,164	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	17,919	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 17,919	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	407	12
13	Barber and Beauty Care	1,705	13
14	Non-Patient Meals	8,114	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	20,534	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 30,760	23
	D. Non-Operating Revenue		
24	Contributions	270,704	24
25	Interest and Other Investment Income***	254,658	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 525,362	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Beneficial Trust (loss on Fair Value)	(1,153,925)	28
28a	Loss on Assets/Stock	(747,988)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (1,901,913)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,060,292	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	931,989	31
32	Health Care	1,100,225	32
33	General Administration	733,408	33
	B. Capital Expense		
34	Ownership	133,185	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	14,866	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,913,673	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,853,382)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,853,382)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,032	2,080	$ 53,551	$ 25.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,306	8,786	201,058	22.88	3
4	Licensed Practical Nurses	13,149	14,094	278,478	19.76	4
5	CNAs & Orderlies	30,939	31,985	326,970	10.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,842	4,181	50,972	12.19	8
9	Activity Director	1,931	2,080	37,607	18.08	9
10	Activity Assistants	4,920	5,137	44,724	8.71	10
11	Social Service Workers	3,502	3,708	53,927	14.54	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,080	36,322	17.46	13
14	Head Cook	6,418	6,773	61,943	9.15	14
15	Cook Helpers/Assistants	15,007	15,594	116,082	7.44	15
16	Dishwashers	3,327	3,439	27,902	8.11	16
17	Maintenance Workers	5,082	5,453	97,485	17.88	17
18	Housekeepers	10,697	11,411	109,258	9.57	18
19	Laundry	2,912	3,115	25,718	8.26	19
20	Administrator	2,032	2,080	76,254	36.66	20
21	Assistant Administrator					21
22	Other Administrative	2,037	2,080	36,000	17.31	22
23	Office Manager	1,920	2,080	32,600	15.67	23
24	Clerical	2,955	3,103	27,086	8.73	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					31
32	Other Health Care(specify)					32
33	Other(specify) Driver	1,216	1,294	10,109	7.81	33
34	TOTAL (lines 1 - 33)	124,176	130,553	$ 1,704,046 *	$ 13.05	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	$ 1,800	V-A1-3	35
36	Medical Director	Contract	2,050	V-B-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	21	945	V-B-10-3	39
40	Physical Therapy Consultant	Contract	1,913	V-B-10a-3	40
41	Occupational Therapy Consultant	6	337	V-B-10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	120	V-B10a-3	43
44	Activity Consultant	4	382	V-B-11-3	44
45	Social Service Consultant	2	103	V-B-12-3	45
46	Other(specify) Chaplain	Contract	2,140	V-B-11-3	46
47	QA Physicians	1	25	V-B-10-3	47
48	Sunday Clergy	38	735	V-B-11-3	48
49	TOTAL (lines 35 - 48)	73	$ 10,550		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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: 01/01/08 Ending: 12/31/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Norman J. Gross	Administrator	0	$ 30,600
Bonnie K. O'Connell	Administrator	0	45,654
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 76,254

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
Clifton&Gunderson	Audit	$ 12,000
Clifton&Gunderson	DataProcess	1,795
EhrmannGehlbachLee	Legal	796
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 14,591

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,961
Unemployment Compensation Insurance	0
FICA Taxes	128,964
Employee Health Insurance	169,733
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	5,850
TOTAL (agree to Schedule V, line 22, col.8)	$ 361,508

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,817
Health Care Worker Background Check	
(Indicate # of checks performed 45)	450
Patient Background Checks 23	230
LSN/AAHSA	2,591
CLIA Laboratory Fees	150
IL Activity/Creative Actv.Dues	165
OWLAPA	50
Non-Allowable Total	34,271
Less: Public Relations Expense	(180)
Non-allowable advertising	(30,433)
Yellow page advertising	(3,658)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,443

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Lisle, IL	24
Chicago, IL	454
Westmont, IL	287
Seminar Expense	
HIPAA Seminar	378
LSN	687
MDS/Census Seminar	160
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,990

**See instructions.

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/08 Ending: 12/31/08

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Heritage Square** **# 0018176** **Report Period Beginning: 01/01/08 Ending: 12/31/08**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $3186**

(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? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,391** Line **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. $ **14,866**
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. $ **10,350**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **90%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Clifton Gunderson LLC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.