

Facility Name & ID Number Heritage Square

0018176 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	9,855	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	49	Sheltered Care (SC)	49	17,885	5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	187			187	8
9	SNF/PED					9
10	ICF	788	8,790		9,578	10
11	ICF/DD					11
12	SC		15,789		15,789	12
13	DD 16 OR LESS					13
14	TOTALS	975	24,579		25,554	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.12%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number

Heritage Square

0018176

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	255,050	23,852	1,966	280,868		280,868		280,868		1
2	Food Purchase		257,866		257,866		257,866	(10,823)	247,043		2
3	Housekeeping	114,201	17,158	341	131,700		131,700		131,700		3
4	Laundry	33,067	8,139		41,206		41,206		41,206		4
5	Heat and Other Utilities			105,455	105,455		105,455	(12,724)	92,731		5
6	Maintenance	100,297	46,853	1,025	148,175		148,175	(5,515)	142,660		6
7	Other (specify):* Waste Removal			3,270	3,270		3,270		3,270		7
8	TOTAL General Services	502,615	353,868	112,057	968,540		968,540	(29,062)	939,478		8
	B. Health Care and Programs										
9	Medical Director			1,825	1,825		1,825		1,825		9
10	Nursing and Medical Records	977,507	41,677	5,818	1,025,002		1,025,002	(4,193)	1,020,809		10
10a	Therapy	42,342		2,216	44,558		44,558		44,558		10a
11	Activities	92,936	6,224	3,425	102,585		102,585		102,585		11
12	Social Services	51,181	270	401	51,852		51,852		51,852		12
13	CNA Training										13
14	Program Transportation		2,025	1,621	3,646		3,646		3,646		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,163,966	50,196	15,306	1,229,468		1,229,468	(4,193)	1,225,275		16
	C. General Administration										
17	Administrative	84,042			84,042		84,042		84,042		17
18	Directors Fees										18
19	Professional Services			16,175	16,175		16,175	(335)	15,840		19
20	Dues, Fees, Subscriptions & Promotions			38,558	38,558		38,558	(31,965)	6,593		20
21	Clerical & General Office Expenses	122,964	18,306	22,349	163,619		163,619	(487)	163,132		21
22	Employee Benefits & Payroll Taxes			418,425	418,425		418,425		418,425		22
23	Inservice Training & Education			296	296		296		296		23
24	Travel and Seminar			1,521	1,521		1,521		1,521		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			77,458	77,458		77,458		77,458		26
27	Other (specify):*										27
28	TOTAL General Administration	207,006	18,306	574,782	800,094		800,094	(32,787)	767,307		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,873,587	422,370	702,145	2,998,102		2,998,102	(66,042)	2,932,060		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:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			142,836	142,836		142,836	142,836	285,672			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			461	461		461	(268,676)	(268,215)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			143,297	143,297		143,297	(125,840)	17,457			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			14,783	14,783		14,783		14,783			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			14,783	14,783		14,783		14,783			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,873,587	422,370	860,225	3,156,182		3,156,182	(191,882)	2,964,300			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:

01/01/09

Ending:

12/31/09

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	10,823	V-A-2-7		4
5	Telephone, TV & Radio in Resident Rooms	12,724	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	268,676	-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	461	-D-32-7		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	487	-C-21-7		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	335	V-C19-7		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	27,311	-C-20-7		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	4,654	-C-20-7		28
29	Other-Attach Schedule Software Purch-Nursing	4,193	-B-10-7		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 329,664		\$	30

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	2	
		Amount	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
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 329,664		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

Heritage Square

Report Period Beginning: 01/01/09
 Ending: 12/31/09

ID# 0018176

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Grounds Maint.	\$ 3,341	V-A-6-7	1
2	Repairs to Furniture	27	V-A-6-7	2
3	Other repairs	475	V-A-6-7	3
4	Other general expense-Maint.	1,059	V-A-6-7	4
5	Misc.Assest-Maint.(Office maint.Use)	613	V-A-6-7	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				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		5,515	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Square# 0018176

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,823)	0	0	0	0	0	0	0	0	0	0	(10,823)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(12,724)	0	0	0	0	0	0	0	0	0	0	(12,724)	5
6	Maintenance	(5,515)	0	0	0	0	0	0	0	0	0	0	(5,515)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(29,062)	0	(29,062)	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	(4,193)	0	0	0	0	0	0	0	0	0	0	(4,193)	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(4,193)	0	(4,193)	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	(335)	0	0	0	0	0	0	0	0	0	0	(335)	19
20	Fees, Subscriptions & Promotions	(31,965)	0	0	0	0	0	0	0	0	0	0	(31,965)	20
21	Clerical & General Office Expenses	(487)	0	0	0	0	0	0	0	0	0	0	(487)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(32,787)	0	(32,787)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(66,042)	0	(66,042)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	142,836	0	0	0	0	0	0	0	0	0	0	142,836	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(268,676)	0	0	0	0	0	0	0	0	0	0	(268,676)	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	(125,840)	0	0	0	0	0	0	0	0	0	0	(125,840)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(191,882)	0	0	0	0	0	0	0	0	0	0	(191,882)	45

Facility Name & ID Number

Heritage Square

0018176

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
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: 01/01/09 Ending: 12/31/09

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

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

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

Facility Name & ID Number Heritage Square

0018176 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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:

01/01/09

Ending:

12/31/09

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	Name of Lender	2		3	4	5	6		8	9	10						
		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	Endowment		X	Endowment	Annual		\$	\$			\$ 461						
2																	
3																	
4																	
5																	
	Working Capital																
6																	
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 461						
	B. Non-Facility Related*																
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$ 461						

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.)

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

1. Real Estate Tax accrual used on 2008 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 2009 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:	2004	8
	2005	9
	2006	10
	2007	11
	2008	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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:

01/01/09 Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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? (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 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Home for Agest</u>	<u>97,046</u>	<u>1963</u>	<u>\$ 42,888</u>	1
2				<u>31,315</u>	2
3	TOTALS	97,046		\$ 74,203	3

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1974	1974	\$ 1,532,081	\$ 38,302	40	\$ 38,302		\$ 1,350,243	4
5			1993	1993	1,100,199	27,505	40	27,505		453,832	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.Actv.(ReassignedB.SP.)		1985	3,229		19			3,229	13
14		Soc.Service Office		1988	1,319		20			1,319	14
15		Roof (HCCwing)		1988	5,940		15			5,940	15
16		Parking Lot		1989	11,398	484	20	484		11,398	16
17		Gutter & Downspouts (S.Wing)		1991	4,500		15			4,500	17
18		Plumbing Replacement		1991	2,099	100	20	100		1,900	18
19		Storage Shed		1991	1,189	56	20	56		1,074	19
20		Fire Alarm Improvement		1991	1,630	77	20	77		1,477	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		15			6,008	23
24		Landscaping (New Wing)		1993	7,749		10			7,749	24
25		Resurface Parking Lot		1993	17,716		15			17,716	25
26		Gutter & Downspouts (N.Wing)		1993	3,600		15			3,600	26
27		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	59	20	59		955	29
30		Painting Facia of Building		1994	1,955		5			1,955	30
31		Life Safety Door Closer (replace)		1995	4,432	275	15	275		4,120	31
32		Patio Sidewalk (Replace)		1995	6,507	309	20	309		4,586	32
33		Soffit Repair (Vinyl)		1995	4,100	195	20	195		2,891	33
34		Attic Ventilation (S.Wing in SC)		1996	11,600	551	20	551		7,598	34
35		Exterior Walks & Drive		1996	3,809	181	20	181		2,494	35
36		Cont'd on 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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	N.E. Outdoor Storage shed	1996	\$ 707	\$ 34	20	\$ 34	\$	\$ 462	37
38	Lighting Replacement(Energy Efficient)	1997	13,031	810	15	810		10,396	38
39	Radiant Heat Panels (S.C.)	1998	19,894	233	10	233		19,894	39
40	Bed Bumper Guards	1998	765		5			765	40
41	8 Attic Exhaust Fans	1998	6,356	302	20	302		3,475	41
42	Kitchen Fire Systems	1998	898	42	20	42		480	42
43	Painting	1999	11,227		5			11,227	43
44	Deposit Bldg.Extens.	2000	2,346						44
45	GFI Electrical Upgrads	2000	4,800	228	20	228		2,084	45
46	Paint Halls & Doors	2001	5,970		5			5,970	46
47	New South Roof	2002	171,935	5,731	30	5,731		41,551	47
48	New North Roof	2003	140,137	4,671	30	4,671		28,806	48
49	Replacement of Clay & Tile & Pvc	2005	1,153	38	30	38		176	49
50	Repair & Replace No.Driveway	2005	9,330	622	15	622		2,540	50
51	Bathroom Tile	2005	1,500	75	20	75		363	51
52	Repair & Waterproof Balcony	2005	6,500	325	20	325		1,435	52
53	Exit/Cylinder Change Room Doors	2005	4,426	221	20	221		977	53
54	Prime & Paint Handrail on Bldg.	2005	3,360	336	10	336		1,428	54
55	New Locks for half of Res.Rooms	2006	2,897	145	20	145		519	55
56	Carpet for offices and entrance	2006	7,307	1,462	5	1,462		5,237	56
57	Concrete Work	2006	2,595	173	15	173		577	57
58	Automatic door for courtyard	2006	2,665	133	20	133		422	58
59	Asphalt half circlce driveway	2006	2,300	153	15	153		498	59
60	Carpet for Residents/Hallways	2007	3,014	302	10	302		779	60
61	Metal Wall	2007	9,523	476	20	476		1,270	61
62	Commodes	2007	1,366	136	10	136		364	62
63	Landscaping/Flowers	2007	250	83	3	83		215	63
64	Fire Alarm Control Panel	2007	8,000	800	10	800		2,067	64
65	Smokes Detectors/horns/strobes	2007	8,763	877	10	877		2,191	65
66	Concrete/Patio	2007	5,860	293	20	293		733	66
67	Wall Station Dukane 4A1225	2007	723	145	5	145		350	67
68	Floor Pedal Sink	2007	380	38	10	38		92	68
69	Cont'd on Page 12B								69
70	TOTAL (lines 4 thru 69)		\$ 3,223,562	\$ 86,978		\$ 86,978	\$	\$ 2,073,226	70

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

Facility Name & ID Number Heritage Square

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,223,562	\$ 86,978		\$ 86,978	\$	\$ 2,073,226	1
2	Actuator Lift 2	2007	1,072	107	10	107		250	2
3	IDPH Fire Imprv.Caulking/FireAlarmPanel	2007	8,755	438	20	438		876	3
4	IDPH-Luse Thermal/Doors,Frames,hardware	2008	19,090	955	20	955		1,909	4
5	IDPH-RollingFireDoor,Luse Thermal	2008	11,580	579	20	579		1,110	5
6	IDPH-RollingFireDoor,Luse Thermal	2008	10,247	512	20	512		854	6
7	Door Locks-Resident Rooms	2008	2,786	139	20	139		255	7
8	Ceramic Tile for 2nd Flr Dining	2008	1,064	106	10	106		106	8
9	New Carpet for Unit A	2008	806	81	10	81		94	9
10	New Carpet	2008	1,511	151	10	151		264	10
11	Cove Base Installation-Carpet/Gluedown	2008	806	81	10	81		128	11
12	ACS Processor (Main Phone System)	2008	1,200	120	10	120		170	12
13	New Cabinets-HCC Dining Area	2008	563	56	10	56		75	13
14	Fire Dampers in Kitchen	2008	1,600	80	20	80		127	14
15	Smoke Dect.,Alarms to Fire Panel	2008	1,300	130	10	130		217	15
16	Frames for Doors	2008	2,846	284	10	284		308	16
17	Doors & Drywall	2008	9,309	465	20	465		504	17
18	Sliding Front Door	2008	5,940	297	20	297		396	18
19	Smoke Dect.,Alarms to Fire Panel	2008	1,580	158	10	158		277	19
20	Fire Alarm Phase II	2008	3,200	320	10	320		320	20
21	New Roof	2008	106,223	3,541	30	3,541		4,721	21
22	Raining-Fabricate/Install on Stairs	2009	3,000	275	10	275		275	22
23	Door-Bookkeepers Office	2009	538	25	20	25		25	23
24	Fire System Upgrade-Phase III Part 1	2009	4,553	417	10	417		417	24
25	Fire System Upgrade-Phase III Part 2	2009	7,320	610	10	610		610	25
26	Stainless Steel Cabinets/Counter-HCC	2009	4,506	338	10	338		338	26
27	Metal Door/Kitchen	2009	1,150	58	10	58		58	27
28	Asphalt/Prime-North Parking Lot	2009	11,430	381	15	381		381	28
29	Kitchen Floor Renov.	2009	21,628	360	20	360		360	29
30	Railings-Courtyard	2009	1,920	64	10	64		64	30
31	Refrigerator Door	2009	3,500	117	10	117		117	31
32	Cabinets-HCC Dining Room	2009	648	5	10	5		5	32
33	Door-Life Safety Code	2009	4,680		20				33
34	TOTAL (lines 1 thru 33)		\$ 3,479,913	\$ 98,228		\$ 98,228	\$	\$ 2,088,837	34

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

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	\$ 682,916	\$ 35,344	\$ 35,344	\$		\$ 366,598	71
72	Current Year Purchases	60,746	6,282	6,282			6,282	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 743,662	\$ 41,626	\$ 41,626	\$		\$ 372,880	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	\$ 2,982	\$ 2,982	\$	4	\$ 13,011	76
77										77
78										78
79										79
80	TOTALS			\$ 13,011	\$ 2,982	\$ 2,982	\$		\$ 13,011	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)	\$ 4,310,789	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 142,836	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 142,836	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)	\$ 2,474,728	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.

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.)

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

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

Facility Name & ID Number Heritage Square# 0018176Report Period Beginning: 01/01/09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,615,909	\$	1
2	Cash-Patient Deposits	30,751		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at <u>cost</u>)	36,186		4
5	Short-Term Investments			5
6	Prepaid Insurance	9,133		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest</u>	19,221		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,711,200	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	35,000		11
12	Long-Term Investments	1,282,765		12
13	Land	74,203		13
14	Buildings, at Historical Cost	3,479,915		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	743,662		16
17	Accumulated Depreciation (book methods)	(2,607,328)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	256,518		21
22	Other Long-Term Assets (spec <u>InPrepetual Trust</u>)	5,006,563		22
23	Other(specify): <u>R.L. Warner Campus</u>	188,305		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,459,603	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,170,803	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 35,809	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,121		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)	\$ 148,930	\$	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)	\$ 148,930	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 11,021,873	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,170,803	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,272,284	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,272,284	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	749,589	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)	\$ 749,589	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 11,021,873	24 *

* This must agree with page 17, line 47.

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,713,801	1
2	Discounts and Allowances for all Levels	(75,931)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,637,870	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,213	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 15,213	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	257	12
13	Barber and Beauty Care	1,952	13
14	Non-Patient Meals	9,227	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	25,028	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 36,464	23
D. Non-Operating Revenue			
24	Contributions	16,049	24
25	Interest and Other Investment Income***	268,676	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 284,725	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Beneficial Trust Income(loss)on fair value	466,208	28
28a	Gain on UnRestricted Net Assets	273,409	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 739,617	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,713,889	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	939,478	31
32	Health Care	1,225,275	32
33	General Administration	767,307	33
B. Capital Expense			
34	Ownership	17,457	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	14,783	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,964,300	40
41	Income before Income Taxes (line 30 minus line 40)**	749,589	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 749,589	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.

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	1,760	1,840	\$ 40,282	\$ 21.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,394	10,974	265,876	24.23	3
4	Licensed Practical Nurses	13,328	14,194	312,335	22.00	4
5	CNAs & Orderlies	36,154	37,760	359,014	9.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,889	4,151	42,342	10.20	8
9	Activity Director	1,906	2,105	39,372	18.70	9
10	Activity Assistants	5,277	5,551	53,564	9.65	10
11	Social Service Workers	3,650	3,874	51,181	13.21	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	37,813	18.18	13
14	Head Cook	6,959	7,357	70,544	9.59	14
15	Cook Helpers/Assistants	15,490	16,057	123,152	7.67	15
16	Dishwashers	2,657	2,844	23,541	8.28	16
17	Maintenance Workers	5,955	6,139	100,297	16.34	17
18	Housekeepers	11,691	12,281	114,201	9.30	18
19	Laundry	3,439	3,702	33,067	8.93	19
20	Administrator	2,246	2,430	84,042	34.59	20
21	Assistant Administrator					21
22	Other Administrative	2,050	2,138	46,885	21.93	22
23	Office Manager	1,928	2,080	34,754	16.71	23
24	Clerical	3,014	3,207	29,339	9.15	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) <u>Driver</u>	1,414	1,494	11,986	8.02	33
34	TOTAL (lines 1 - 33)	135,193	142,258	\$ 1,873,587 *	\$ 13.17	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	\$ 1,966	35
36	Medical Director	Contract	1,825	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	35	1,575	39
40	Physical Therapy Consultant	Contract	2,156	40
41	Occupational Therapy Consultant	1	60	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	2	325	44
45	Social Service Consultant	1	200	45
46	Other(specify) <u>Chaplain</u>	Contract	2,200	46
47	<u>QA Pyhsicians</u>	2	50	47
48	<u>Sunday Clergy</u>	40	900	48
49	TOTAL (lines 35 - 48)	81	\$ 11,257	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Bonnie K. O'Connell	Administrator	0	\$ 84,042	Workers' Compensation Insurance	\$ 82,311	IDPH License Fee	\$	
				Unemployment Compensation Insurance	1,062	Advertising: Employee Recruitment		
				FICA Taxes	148,123	Health Care Worker Background Check		
				Employee Health Insurance	182,660	(Indicate # of checks performed 48)		
				Employee Meals		Patient Background Checks	22	
				Illinois Municipal Retirement Fund (IMRF)*		LSN/AAHSA		
				Employee Physicals	4,269	ILActv./Creative/Actv.Dues		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 84,042	TOTAL (agree to Schedule V, line 22, col.8)		\$ 418,425		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Chicago	
							Moline	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense	
C. Professional Services							NIU/LSN	
Vendor/Payee	Type		Amount				MDS/Update/SocSv/Admnr	
Clifton& Gunderson	Audit		\$ 12,000				OSHA	
Clifton& Gunderson	DataProcess		2,375				Entertainment Expense	
EhrmannGehlbachLee	Legal		635				(agree to Sch. V, line 24, col. 8)	
Green & Assoc.	Architects		1,165				TOTAL	
							\$	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 16,175					

* Attach copy of IMRF notifications

**See instructions.

Page 21

12/31/09

Amount
1,360
500
220
4,318
195
31,965
(28)
(27,283)
(4,654)
6,593

Amount
153
221
430
647
70
0)
1,521

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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
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:

01/01/09

Ending:

12/31/09

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- \$4368
- (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. \$ 11,385 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. \$ 14,783
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. \$ 10,823
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 90%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Clifton Gunderson LLC
- (18) Have all costs which do not relate to the provision of long term care been adjusted 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.