

Facility Name & ID Number Heritage Square

0018176 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	305			305	8
9	SNF/PED					9
10	ICF	1,685	6,127		7,812	10
11	ICF/DD					11
12	SC		16,985		16,985	12
13	DD 16 OR LESS					13
14	TOTALS	1,990	23,112		25,102	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.24%

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	299,884	29,688	1,650	331,222		331,222		331,222		1
2	Food Purchase		268,605		268,605		268,605	(9,277)	259,328		2
3	Housekeeping	110,660	45,413		156,073		156,073		156,073		3
4	Laundry	66,518	11,276		77,794		77,794		77,794		4
5	Heat and Other Utilities			136,780	136,780		136,780	(21,608)	115,172		5
6	Maintenance	101,559	92,328	163	194,050		194,050	(7,727)	186,323		6
7	Other (specify):* Waste Removal			7,920	7,920		7,920		7,920		7
8	TOTAL General Services	578,621	447,310	146,513	1,172,444		1,172,444	(38,612)	1,133,832		8
	B. Health Care and Programs										
9	Medical Director			1,725	1,725		1,725		1,725		9
10	Nursing and Medical Records	1,056,688	64,241	13,233	1,134,162		1,134,162		1,134,162		10
10a	Therapy	132,850		4,011	136,861		136,861		136,861		10a
11	Activities	98,525	1,549	5,089	105,163		105,163	(150)	105,013		11
12	Social Services	60,284	1,555	1,808	63,647		63,647		63,647		12
13	CNA Training										13
14	Program Transportation		3,150		3,150		3,150		3,150		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,348,347	70,495	25,866	1,444,708		1,444,708	(150)	1,444,558		16
	C. General Administration										
17	Administrative	100,681			100,681		100,681		100,681		17
18	Directors Fees										18
19	Professional Services			15,812	15,812		15,812		15,812		19
20	Dues, Fees, Subscriptions & Promotions			47,002	47,002		47,002	(35,477)	11,525		20
21	Clerical & General Office Expenses	144,759	25,098	8,113	177,970		177,970	(5,627)	172,343		21
22	Employee Benefits & Payroll Taxes			561,906	561,906		561,906		561,906		22
23	Inservice Training & Education			9,850	9,850		9,850		9,850		23
24	Travel and Seminar			971	971		971	(40)	931		24
25	Other Admin. Staff Transportation			1,096	1,096		1,096		1,096		25
26	Insurance-Prop.Liab.Malpractice			42,330	42,330		42,330		42,330		26
27	Other (specify):* Sat.TempRestriFund			10,881	10,881		10,881	(10,881)			27
28	TOTAL General Administration	245,440	25,098	697,961	968,499		968,499	(52,025)	916,474		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,172,408	542,903	870,340	3,585,651		3,585,651	(90,787)	3,494,864		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:

01/01/2016

Ending:

12/31/2016

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			178,756	178,756		178,756		178,756			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(412,320)	(412,320)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Unemployment Expense			6,362	6,362		6,362	(6,362)				36
37	TOTAL Ownership			185,118	185,118		185,118	(418,682)	(233,564)			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,882	63,882		63,882		63,882			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			63,882	63,882		63,882		63,882			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,172,408	542,903	1,119,340	3,834,651		3,834,651	(509,469)	3,325,182			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

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Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	9,277	V-A-2-7		4
5	Telephone, TV & Radio in Resident Rooms	21,608	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	412,320	-D-32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	5,627	-C-21-7		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	31,817	-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	3,660	-C-20-7		28
29	Other-Attach Schedule See 5A	25,160			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 509,469		\$	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	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))	\$ 509,469		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

Heritage Square

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Report Period Beginning: 01/01/2016

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Repairs to Maint. Equipment	\$ 1,911	V-A-2-7	1
2	Grounds Maint.	5,370	V-A-2-7	2
3	Gas,Oil,Grease for Maint. Eqpt.	446	V-A-2-7	3
4	Piano Tuning	150	V-B-3-7	4
5	Maint.-Travel to pick up part	40	V-C-24-7	5
6	Satisfaction of Temporary Restricted Funds	10,881	V-C-27-7	6
7	Unemployment Expense	6,362	V-D-36-7	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	25,160		49

STATE OF ILLINOIS

Summary A

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

01/01/2016

Ending: 12/31/2016

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	(9,277)	0	0	0	0	0	0	0	0	0	0	(9,277)	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	(21,608)	0	0	0	0	0	0	0	0	0	0	(21,608)	5
6	Maintenance	(7,727)	0	0	0	0	0	0	0	0	0	0	(7,727)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(38,612)	0	(38,612)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(150)	0	0	0	0	0	0	0	0	0	0	(150)	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	(150)	0	(150)	16									
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(35,477)	0	0	0	0	0	0	0	0	0	0	(35,477)	20
21	Clerical & General Office Expenses	(5,627)	0	0	0	0	0	0	0	0	0	0	(5,627)	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	(40)	0	0	0	0	0	0	0	0	0	0	(40)	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):*	(10,881)	0	0	0	0	0	0	0	0	0	0	(10,881)	27
28	TOTAL General Administration	(52,025)	0	(52,025)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(90,787)	0	(90,787)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(412,320)	0	0	0	0	0	0	0	0	0	0	(412,320)	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):* Unemployment Ex	(6,362)	0	0	0	0	0	0	0	0	0	0	(6,362)	36
37	TOTAL Ownership	(418,682)	0	(418,682)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(509,469)	0	(509,469)	45									

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost 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

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Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	William Reigle-President	BOD						2
3	Patrick Jones, Sr.-Vice President	BOD						3
4	Judge Charles Beckman-Secretary	BOD						4
5	James Sarver, Treasurer	BOD						5
6	Kenda Bailey	BOD						6
7	Dr. Tim Appenheimer	BOD						7
8	Patti Balayti	BOD						8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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:

01/01/2016

Ending: 2/31/2016

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	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

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01/01/2016

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12/31/2016

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

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.)

2015 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 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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:

01/01/2016 Ending:

12/31/2016

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 Seniors</u>	<u>97,046</u>	<u>1963</u>	<u>\$ 42,888</u>	<u>1</u>
2				<u>31,315</u>	<u>2</u>
3	TOTALS	97,046		\$ 74,203	3

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$	40	\$	\$	\$ 1,532,081	4
5		1993	1993	1,100,199	27,505	40	27,505		673,872	5
6										6
7										7
8										8
Improvement Type**										
9	Patio Cover		1980	3,729		20			3,729	9
10	Physical Therapy Room		1985	18,461		18			18,461	10
11	Activity Room LL		1985	3,229		15			3,229	11
12	Soc.Serv.Office		1988	1,319		5			1,319	12
13	Drain Line Trough		1991	2,099		5			2,099	13
14	Storage Shed		1991	1,189		20			1,189	14
15	Fire Alarm Wiring		1991	1,630		5			1,630	15
16	Gutter & Downspouts (S. Wing)		1991	4,500		15			4,500	16
17	Airphone Intercom Improvement		1992	508		15			508	17
18	Beam Fire Protection		1993	1,380		10			1,380	18
19	Concrete Drive Walks		1993	6,008		15			6,008	19
20	Landscaping (New Wing)		1993	7,749		10			7,749	20
21	Resurface Parking Lot		1993	17,716		15			17,716	21
22	Gutter & Downspouts (N. Wing)		1993	3,600		15			3,600	22
23	Concrete Walk & Bench Pad		1994	1,225		20			1,225	23
24	Safety Door Shield		1994	1,250		10			1,250	24
25	Life Safety Door Closer (replace)		1995	4,432		15			4,432	25
26	Patio Sidewalk (replace)		1995	6,507		20			6,363	26
27	Soffit Repair (Vinyl)		1995	4,100	56	20	56		4,100	27
28	Walk Drive Approach		1996	3,809	121	20	121		3,700	28
29	Patio Sidewalk (replace)		1995	6,507	144	20	144		6,507	29
30	Storage Shed		1996	707	20	20	20		707	30
31	Lighting Replacement (Energy Efficient)		1997	13,031		15			13,031	31
32	Radiant Heat Panels		1998	19,894		10			19,894	32
33	Kitchen Fire System		1998	898	43	20	43		823	33
34	Painting		1999	11,227		5			11,227	34
35	GFI electric update		2000	4,800	228	20	228		3,908	35
36	See Page 12A									36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	New So. Roof	2002	\$ 171,935	\$ 5,731	30	\$ 5,731	\$	\$ 87,399	37
38	New North Roof	2003	140,137	4,671	30	4,671		66,175	38
39	Bathroom Tile	2005	1,500	75	20	75		963	39
40	Replacement of PVC & Clay Tile/Sewer	2005	1,153	38	30	38		481	40
41	Exit/Cylinder Change Room Doors	2005	4,426	221	20	221		2,746	41
42	New Locks for Half of the Resident Rooms	2006	2,897	145	20	145		1,679	42
43	Concrete Work	2006	2,595	173	15	173		1,961	43
44	Asphalt half circle driveway	2006	2,300	153	15	153		1,723	44
45	Automatic door for courtyard	2006	2,665	133	20	133		1,487	45
46	Metal Wall	2007	9,523	476	20	476		5,078	46
47	Commodos	2007	1,366	44	10	44		1,366	47
48	Carpet	2007	3,014	126	10	126		3,014	48
49	Fire Alarm Control Panel	2007	8,000	333	10	333		1,788	49
50	Smoke detectors,horns/strobes,etc.	2007	8,763	438	10	438		8,762	50
51	Concrete/Patio	2007	5,860	293	20	293		3,077	51
52	Floor Pedal Sink	2007	380	22	10	22		380	52
53	Actuator (Lifts)-2	2007	1,072	71	10	71		1,071	53
54	IDPH Fire Improvements	2007	8,755	438	20	438		4,379	54
55	IDPH Fire Improvement-Doors,Frames,hardware	2008	19,090	955	20	955		9,547	55
56	IDPH Fire Improvements-Luse Thermal Firestopping	2008	11,580	579	20	579		5,742	56
57	New Locks for Residents	2008	2,786	139	20	139		1,368	57
58	IDPH Fire Improvements - rolling fire door	2008	10,247	512	20	512		4,951	58
59	Smoke Detector,Door Alarm Lite	2008	1,580	158	10	158		1,541	59
60	Smoke Detectors, alarms, etc.	2008	1,300	130	10	130		1,257	60
61	Fire Dampers in Kitchen	2008	1,600	80	20	80		767	61
62	Glue Down Carpet, Cove Base Install	2008	806	81	10	81		775	62
63	ACS Processor (Main Phone System)	2008	1,200	120	10	120		1,130	63
64	New Cabinets - HCC Dining Area	2008	563	56	10	56		524	64
65	Sliding Door	2008	5,940	297	20	297		2,772	65
66	New Roof	2008	106,223	3,541	30	3,541		33,048	66
67	New Carpet for Unit A	2008	806	81	10	81		741	67
68	Frames for Doors	2008	2,846	285	10	285		2,587	68
69	Doors & Drywall	2008	9,309	465	20	465		4,226	69
70	TOTAL (lines 4 thru 69)		\$ 3,336,001	\$ 49,177		\$ 49,177	\$	\$ 2,620,742	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:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 3,336,001	\$ 49,177		\$ 49,177	\$	\$ 2,620,742	1
2	Creamic tile for 2nd Floor (HCC) Diningroom	2008	1,064	106	10	106		956	2
3	Fire Alarm Phase II	2008	3,200	320	10	320		2,880	3
4	Fabricate & Install Railings on Stair	2009	3,000	300	10	300		2,675	4
5	Bookkeeper's Door	2009	538	27	20	27		240	5
6	Fire System Update-Phase III	2009	4,553	455	10	455		4,058	6
7	Fire System Update-Phase III	2009	7,320	732	10	732		6,466	7
8	Stainless Steel Bench/Counter/Cabinets	2009	4,506	451	10	451		3,945	8
9	Hollow Metal Door/Kitchen	2009	1,150	115	10	115		978	9
10	Kitchen Renovation	2009	21,628	1,081	20	1,081		9,010	10
11	Fabricate Railing for Court Yard	2009	1,920	192	10	192		1,600	11
12	Cabinets-HCC Dining Room	2009	648	65	10	65		525	12
13	Door-Life Safety Code	2009	4,680	234	20	234		1,872	13
14	Counter Tops for HCC	2010	394	6	7	6		394	14
15	Sidewalk-McKinney to Morgan on Brinton Ave	2010	3,400	227	15	227		1,683	15
16	Beauty Shop Flooring	2011	936	94	10	94		626	16
17	Maintenance Room-Steel Door	2011	978	49	20	49		298	17
18	Steel Door/Frame-Soc.Svc.	2012	2,861	286	10	286		1,716	18
19	Shunt Trip Breaker-Elevator	2012	1,983	198	10	198		1,188	19
20	Circuitry,Switch&Can Lights-Dining Room	2012	450	60	5	60		450	20
21	Carpet Room 37 & 38	2012	3,674	489	5	489		3,674	21
22	Kitchen Serve Button/Breakers	2012	1,050	140	5	140		1,050	22
23	Elevator Phone	2012	99	14	5	14		99	23
24	PTACS	2012	22,296	2,230	10	2,230		11,707	24
25	Automatic Sprinkler System	2012	140,225	7,011	20	7,011		34,471	25
26	Stainless Steel Cover for Ice Chest	2013	795	159	5	159		782	26
27	Water Heater	2013	24,114	2,411	10	2,411		11,653	27
28	Washer	2013	7,539	1,508	5	1,508		7,289	28
29	Printer-HCC	2013	771	154	5	154		732	29
30	Mixer Valve for Water Heater	2013	2,075	415	5	415		1,971	30
31	PTACS	2013	14,857	2,971	5	2,971		13,617	31
32	Wireless/Computer for HCC	2013	7,371	1,474	5	1,474		6,756	32
33	Fax Machines	2013	1,000	200	5	200		83	33
34	TOTAL (lines 1 thru 33)		\$ 3,627,076	\$ 73,351		\$ 73,351	\$	\$ 2,756,186	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:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 12B, Carried Forward		\$ 3,627,076	\$ 73,351		\$ 73,351	\$	\$ 2,756,186	1
2	Heat/Cool Unit	2013	2,750	550	5	550		2,429	2
3	Concrete Sidewalk - North End	2013	6,775	1,355	5	1,355		5,985	3
4	Computer & Monitor for Activies/Programs	2013	1,181	236	5	236		1,023	4
5	Computer-Administrator	2013	953	191	5	191		812	5
6	Tile-HCC Room	2013	1,323	265	5	265		1,126	6
7	2 Fire Rings - Per IDPH	2013	403	81	5	81		344	7
8	Carpet - Room 11	2013	885	177	5	177		738	8
9	Generator Circuits	2013	7,984	1,597	5	1,597		6,521	9
10	Electrical Upgrade on HCC	2013	1,500	300	5	300		1,225	10
11	MDS Software-PointClickCare	2013	15,929	3,186	5	3,186		13,010	11
12	Stainless Plates for Dining Room Wall	2013	741	148	5	148		592	12
13	Carpet- Room 5 SC	2013	931	186	5	186		744	13
14	Concentrator	2013	570	114	5	114		456	14
15	Additional Water Heater Costs	2014	1,040	104	10	104		416	15
16	Baseboard Heater	2014	935	187	5	187		732	16
17	Washer	2014	875	175	5	175		671	17
18	Wireless Internet	2014	1,845	369	5	369		1,384	18
19	Tile: Room 209	2014	1,786	357	5	357		1,339	19
20	PC for HCC (Wireless w/Mount	2014	710	142	5	142		533	20
21	VESA Mount Compatible PC	2014	885	177	5	177		634	21
22	Central Air (Kitchen)	2014	6,700	1,340	5	1,340		4,802	22
23	PTACs (13)	2014	19,447	3,889	5	3,889		13,612	23
24	Mattress-HCC	2014	536	107	5	107		375	24
25	Time Clock on Site Lighting	2014	500	100	5	100		342	25
26	Outdoor Horn/Strobe	2014	680	136	5	136		465	26
27	Control Valve-Elevator	2014	742	148	5	148		493	27
28	Computer-MDS Coordinator	2014	750	150	5	150		488	28
29	Elevator Equipment	2014	6,005	1,201	5	1,201		3,903	29
30	Astragal Seals Door & Installation	2014	2,100	420	5	420		1,365	30
31	Web Design	2014	1,222	244	5	244		793	31
32	Steam Table	2014	642	128	5	128		405	32
33	Cont'd on Page 12D								33
34	TOTAL (lines 1 thru 33)		\$ 3,716,401	\$ 91,111		\$ 91,111	\$	\$ 2,823,943	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:

01/01/2016 Ending: 12/31/2016

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 12C, Carried Forward		\$ 3,716,401	\$ 91,111		\$ 91,111	\$	\$ 2,823,943	1
2	Solid State Starter (Elevator)	2014	2,588	518	5	518		1,554	2
3	2nd Payment on Steamer	2015	642	128	5	128		363	3
4	Reclining Tub/HCC	2015	14,440	2,888	5	2,888		7,942	4
5	Mattress-HCC	2015	587	117	5	117		302	5
6	Furnish/Install Magic Force (Door)	2015	2,160	108	20	108		270	6
7	Installed Bumper Poles	2015	1,200	120	10	120		290	7
8	Seal Coating	2015	3,590	239	15	239		578	8
9	New Door Knobs for Res. Doors	2015	1,578	79	20	79		191	9
10	Plastering Balconey HCC-Final	2015	2,300	153	15	153		370	10
11	Carpet-HCC/tiles-Shower	2015	1,569	157	10	157		379	11
12	Automatic Stanley Door	2015	2,160	108	20	108		261	12
13	Heritage Square Sign	2015	12,450	830	15	830		1,798	13
14	Repair HCC Balconey/Poured pad (sign)/sidewalk	2015	4,690	313	15	313		652	14
15	Dining Room tile/carpet	2015	66,091	6,609	10	6,609		14,320	15
16	PTACS (11)	2015	16,298	3,260	5	3,260		6,520	16
17	Carpet-SC Hallways	2016	11,660	2,332	5	2,332		2,915	17
18	Refacing Interior Doors	2016	1,632	326	5	326		380	18
19	Nursing Call System	2016	143,580	28,716	5	28,716		28,716	19
20	Tile Flooring - Dining room/Nurses station	2016	18,475	3,695	5	3,695		3,695	20
21								339	21
22								112	22
23								217	23
24								222	24
25								153	25
26								823	26
27								621	27
28								7,711	28
29								968	29
30								339	30
31								3,260	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,024,091	\$ 141,807		\$ 141,807	\$	\$ 2,910,204	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 746,403	\$ 33,412	\$ 33,412	\$		\$ 279,024	71
72	Current Year Purchases	30,073	6,014	6,014			6,014	72
73	Fully Depreciated Assets	(54,631)	(3,808)	(3,808)			(48,812)	73
74								74
75	TOTALS	\$ 721,845	\$ 35,618	\$ 35,618	\$		\$ 236,226	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2004 Buick LeSabre	2012	\$ 11,405	\$ 1,331	\$ 1,331	\$	5	\$ 11,405	76
77										77
78										78
79										79
80	TOTALS			\$ 11,405	\$ 1,331	\$ 1,331	\$		\$ 11,405	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,831,544	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 178,756	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,756	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,157,835	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: 01/01/2016

Ending: 12/31/2016

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.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(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	\$ 208,668	\$	1
2	Cash-Patient Deposits	100,900		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at Cost)	53,439		4
5	Short-Term Investments			5
6	Prepaid Insurance	10,612		6
7	Other Prepaid Expenses	6,787		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest</u>	21,592		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 401,998	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,261,387		12
13	Land	74,203		13
14	Buildings, at Historical Cost	4,022,996		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	644,991		16
17	Accumulated Depreciation (book methods)	(3,275,474)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,756,169		21
22	Other Long-Term Assets (spe <u>In Perpetual Trust</u>	5,549,866		22
23	Other(specify): <u>R.L. Warner Campus</u>	148,305		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,182,443	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,584,441	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 55,147	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,303		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)	\$ 268,450	\$	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)	\$ 268,450	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,315,991	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,584,441	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,095,840	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,095,840	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	220,151	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)	\$ 220,151	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)	\$ 11,315,991	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,406,085	1
2	Discounts and Allowances for all Levels	(365,046)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,041,039	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	19,982	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 19,982	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	77	12
13	Barber and Beauty Care	2,390	13
14	Non-Patient Meals	9,277	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	30,313	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 42,057	23
D. Non-Operating Revenue			
24	Contributions	147,979	24
25	Interest and Other Investment Income***	412,320	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 560,299	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Beneficial Trust Income on Fair Value	282,925	28
28a	Gain(Loss)on Fair Value	108,500	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 391,425	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,054,802	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,172,444	31
32	Health Care	1,444,708	32
33	General Administration	968,499	33
B. Capital Expense			
34	Ownership	178,756	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	63,882	36
D. Other Expenses (specify):			
37	Unemployment Expense	6,362	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,834,651	40
41	Income before Income Taxes (line 30 minus line 40)**	220,151	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 220,151	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 255,977	44
45	Private Pay - Net Inpatient Revenue	2,785,062	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,041,039	49

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

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

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

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

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	2,042	2,122	\$ 57,698	\$ 27.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,522	13,855	274,228	19.79	3
4	Licensed Practical Nurses	11,420	12,577	329,566	26.20	4
5	CNAs & Orderlies	33,113	33,814	385,958	11.41	5
6	CNA Trainees	9	9	87	9.67	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,084	6,391	90,923	14.23	8
9	Activity Director	3,600	3,895	59,813	15.36	9
10	Activity Assistants	3,803	3,889	37,742	9.70	10
11	Social Service Workers	3,859	4,206	59,316	14.10	11
12	Dietician					12
13	Food Service Supervisor	1,897	2,101	40,125	19.10	13
14	Head Cook	6,875	7,164	75,814	10.58	14
15	Cook Helpers/Assistants	15,236	15,844	151,969	9.59	15
16	Dishwashers	2,589	2,674	28,806	10.77	16
17	Maintenance Workers	5,461	5,604	101,559	18.12	17
18	Housekeepers	11,713	12,192	128,543	10.54	18
19	Laundry	4,207	4,535	47,146	10.40	19
20	Administrator	2,261	2,393	100,681	42.07	20
21	Assistant Administrator					21
22	Other Administrative	1,911	2,087	65,923	31.59	22
23	Office Manager	1,995	2,163	34,981	16.17	23
24	Clerical	2,281	2,382	24,619	10.34	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	427	427	2,921	6.84	31
32	Other Health C: <u>MDS Coordinator</u>	1,937	1,995	56,924	28.53	32
33	Other(specify) <u>Driver</u>	1,524	1,611	17,066	10.59	33
34	TOTAL (lines 1 - 33)	137,766	143,930	\$ 2,172,408 *	\$ 15.09	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	\$ 1,650	V-A-1-3	35
36	Medical Director	Contract	1,725	V-B-9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	46	1,225	V-B-10-3	38
39	Pharmacist Consultant	49	2,002	V-B-10-3	39
40	Physical Therapy Consultant	Contract	2,709	V-B-10a-3	40
41	Occupational Therapy Consultant	Contract	1,302	V-B-10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	26	1,864	V-B-11-3	44
45	Social Service Consultant	24	1,808	V-B-12-3	45
46	Other(specify) <u>Chaplain</u>	Contract	2,150	V-B-11-3	46
47	<u>Sunday Clergy</u>	37	925	V-B-12-3	47
48	<u>MDS Software/Computer Svc</u>	Contract	7,940	V-B-10-3	48
49	TOTAL (lines 35 - 48)	182	\$ 25,300		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		\$ 99,923	Workers' Compensation Insurance	\$ 97,550	IDPH License Fee	\$		
				Unemployment Compensation Insurance	6,362	Advertising: Employee Recruitment	7,097		
				FICA Taxes	156,161	Health Care Worker Background Check	731		
				Employee Health Insurance	290,914	(Indicate # of checks performed 22)			
				Employee Meals		Patient Background Checks	26		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	275		
				Employee Physicals	6,232	Dues	3,162		
				CPR Training	440				
				Employee Vaccinations	4,247				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 99,923	TOTAL (agree to Schedule V, line 22, col.8)		\$ 11,525			
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		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Soc.Svc.-Assess/Res.Care	124	
C. Professional Services							Springfield,IL_Admsn-SemIDPH	125	
Vendor/Payee	Type		Amount				EastPeoria, IL-INHAA Confr.	95	
EhrmannGehlbachBadger			\$				Seminar Expense		
Lee & Considine	Legal		938				Seminar-Springfield/IDPH	379	
CliftonLarsonAllen	Audit/CPA		14,874				Seminar-E.Peoria-2 day-Nursing	208	
							Home Future and New Codes		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 15,812	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 931

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LeadingAge Illinois \$3162
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,241 Line V-B-10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 63,882
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. \$ 9,277
- (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: CliftonLarsonAllenLLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees