

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0018176

Facility Name: Heritage Square

Address: 620 North Ottawa Ave Dixon 61021
Number City Zip Code

County: Lee

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

HFS ID Number:

Date of Initial License for Current Owners: 11/08/1974

Type of Ownership:

☒ VOLUNTARY,NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501c(3)

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

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

Paid
Preparer

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Heritage Square

0018176 Report Period Beginning: 01/01/2016 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	<u>27</u>	Skilled (SNF)	<u>27</u>	<u>9,882</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>49</u>	Sheltered Care (SC)	<u>49</u>	<u>17,934</u>	5
6		ICF/DD 16 or Less			6
7	<u>76</u>	TOTALS	<u>76</u>	<u>27,816</u>	7

B. Census-For the entire report period.

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
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.

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
(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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	(52,025)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(90,787)	0	0	0	0	0	0	0	0	0	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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(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	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2016 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:		2011 8 2012 9 2013 10 2014 11 2015 12	FOR BHF USE ONLY	
			13 FROM R. E. TAX STATEMENT FOR 2015 \$	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.

FACILITY NAME	<u>Heritage Square</u>	COUNTY	<u>Lee</u>
---------------	------------------------	--------	------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

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.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,354

B. General Construction Type: Exterior BrickFrame Steel Griders MetalNumber 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?
If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

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

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

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): Accrued Interest	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 (specify: In Perpetual Trust)	5,549,866		22
23	Other(specify): R.L. Warner Campus	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
36	Other Current Liabilities(specify):			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
43	Other Long-Term Liabilities(specify):			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

1			
	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

2			
	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	<u>Unemployment Expense</u>	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.

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 Care MDS Coordinator	1,937	1,995	56,924	28.53	32
33	Other(specify) Driver	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) Chaplain	Contract	2,150	V-B-11-3	46
47	Sunday Clergy	37	925	V-B-12-3	47
48	MDS Software/Computer Svc	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	260		
				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								
B. Administrative - Other											
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)				
			\$	\$ 561,906			\$ 11,525				
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
EhrmannGehlbachBadger			\$			\$	Out-of-State Travel		\$		
Lee & Considine	Legal		938								
CliftonLarsonAllen	Audit/CPA		14,874								
							In-State Travel				
							Soc.Svc.-Assess/Res.Care		124		
							Springfield,IL_Admsn-SemIDPH		125		
							EastPeoria, IL-INHAA Confr.		95		
							Seminar Expense				
							Seminar-Springfield/IDPH		379		
							Seminar-E.Peoria-2 day-Nursing		208		
							Home Future and New Codes				
							Entertainment Expense	(	)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)				
(For legal fee disclosure, see page 39 of instructions)			\$ 15,812	\$			TOTAL \$ 931				

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes

LeadingAge Illinois \$3162

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

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?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

(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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$

63,882

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$

0

Yes

Indicate the amount.

\$

9,277

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

\$

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

\$

0

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes

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.
Attach invoices and a summary of services for all architect and appraisal fees

Yes