

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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 N Ottawa Avenue Dixon 61021

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:

X

VOLUNTARY,NON-PROFIT

X

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: Larry Templin

Telephone Number: (630) 361-2868

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 1/1/2025 to 12/31/2025 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)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326

(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Heritage Square # 0018176 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	27	Skilled (SNF)	27	9,855	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	49	Sheltered Care (SC)	49	17,885	5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF	77		730		7,318			8,125	10
11	ICF/DD									11
12	SC					14,550			14,550	12
13	DD 16 OR LESS									13
14	TOTALS	77		730		21,868			22,675	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 81.74%

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

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

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 certified beds.
number of certified beds _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/25 Fiscal Year: 12/31/25

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

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	471,286	1,767	3,096	476,149		476,149		476,149			1
2	Food Purchase		357,272		357,272		357,272	(1,410)	355,862			2
3	Housekeeping	212,442	33,969	1,811	248,222		248,222		248,222			3
4	Laundry	80,360	10,512		90,872		90,872		90,872			4
5	Heat and Other Utilities			164,328	164,328		164,328		164,328			5
6	Maintenance	114,827	85,241	17,340	217,408		217,408	(451)	216,957			6
7	Other (specify):* Disposal			7,214	7,214		7,214		7,214			7
8	TOTAL General Services	878,915	488,761	193,789	1,561,465		1,561,465	(1,861)	1,559,604			8
	B. Health Care and Programs											
9	Medical Director			1,450	1,450		1,450		1,450			9
10	Nursing and Medical Records	1,988,699	77,670	3,578	2,069,947		2,069,947		2,069,947			10
10a	Therapy											10a
11	Activities	139,179	13,425	2,518	155,122		155,122		155,122			11
12	Social Services	83,178	549	2,070	85,797		85,797		85,797			12
13	CNA Training											13
14	Program Transportation			543	543		543		543			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,211,056	91,644	10,159	2,312,859		2,312,859		2,312,859			16
	C. General Administration											
17	Administrative	123,338			123,338		123,338		123,338			17
18	Directors Fees											18
19	Professional Services			94,198	94,198		94,198	(1,011)	93,187			19
20	Dues, Fees, Subscriptions & Promotions			5,882	5,882		5,882	(1,988)	3,894			20
21	Clerical & General Office Expenses	156,830	29,006	19,127	204,963		204,963	(1,803)	203,160			21
22	Employee Benefits & Payroll Taxes			569,996	569,996		569,996		569,996			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,017	4,017		4,017		4,017			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			127,756	127,756		127,756		127,756			26
27	Other (specify):*											27
28	TOTAL General Administration	280,168	29,006	820,976	1,130,150		1,130,150	(4,802)	1,125,348			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,370,139	609,411	1,024,924	5,004,474		5,004,474	(6,663)	4,997,811			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' PREPARATION REPORT
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			96,555	96,555		96,555	(3,681)	92,874			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,384	6,384		6,384		6,384			35
36	Other (specify):*											36
37	TOTAL Ownership			102,939	102,939		102,939	(3,681)	99,258			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			5,368	5,368		5,368		5,368			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			4,003	4,003		4,003	(631)	3,372			41
42	Provider Participation Fee			93,831	93,831		93,831		93,831			42
43	Other (specify):* Disallowed Costs			394,174	394,174		394,174	(394,174)				43
44	TOTAL Special Cost Centers			497,376	497,376		497,376	(394,805)	102,571			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,370,139	609,411	1,625,239	5,604,789		5,604,789	(405,149)	5,199,640			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' PREPARATION REPORT

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	(653)	2		4
5	Telephone, TV & Radio in Resident Rooms	(33,220)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,681)	30		9
10	Interest and Other Investment Income				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	(25)	20		17
18	Fines and Penalties	(1,243)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(267,571)	43		24
25	Fund Raising, Advertising and Promotional	(7,300)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		43		28
29	Other-Attach Schedule See Page 5A	(91,456)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (405,149)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (405,149)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ 0	201
2	Other Expenses Related to Lobbying Activities		2
3			3
4	Disallow Satisfaction of Temp Restrict	(11,166)	434
5	Offset Rebates	(757)	25
6	Offset Misc Income	(19)	216
7	Offset Pop Machine Income	(631)	417
8	Disallow Flowers Expense	(1,784)	218
9	Disallow Donation Booklet	(720)	209
10	Disallow Grant Expense	(1,011)	1910
11	Disallow Loss on Investments	(62,804)	4311
12	Disallow Bank/Invest Fees	(9,939)	4312
13	Expense Repairs/Improvements under \$2,500	3,105	613
14	Disallow Maintenance Wages for Warner Campus	(3,556)	614
15	Disallow Loss on Sale of Fixed Asset	(2,174)	4315
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	(91,456)	49

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
		N/A		N/A		

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

X 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.

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Ownership Listing-1

Heritage Square

ID#0018176

Report Period Beginning:1/1/2025

Ending:12/31/2025

N/A

N/A

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Operator/Licensee

Building Co.

Management Co./Home Office

First Name

M.I.

Last Name

City

State

Ownership Percentage

Ownership Percentage

Ownership Percentage

1	Board of Directors:							1
2	Patrick		Jones, Jr.-President					2
3	Debra		Didier-Vice President					3
4	Kenda		Bailey-Treasurer & Secretary					4
5	Thomas		Densmore					5
6	Doug		Lee					6
7	Charles		Beckman-Retired Judge					7
8	Randall		Renne					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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70								70
71								71
72								72
73								73
74								74
75								75

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	N/A										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

SEE ACCOUNTANTS' PREPARATION REPORT

Ending: 2/31/2025

Fax Number**SEE ACCOUNTANTS' PREPARATION REPORT**

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	N/A												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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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

SEE ACCOUNTANTS' PREPARATION REPORT

FACILITY NAME Heritage Square COUNTY Lee

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

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

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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.

K. 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	
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

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	76		1974	1974	\$ 1,532,081	\$		\$		\$ 1,532,081	4
5			1993	1993	1,100,199	27,505	40	27,505		893,912	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		19			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	Wiring of Fire Alarm		1991		1,630		5			1,630	14
15	Gutter Downspouts		1991		4,500		15			4,500	15
16	Aiphone Intercom		1992		508		15			508	16
17	Beam Fire Protection		1993		1,380		10			1,380	17
18	Concrete Drive Walks		1993		6,008		15			6,008	18
19	Trees Shrubs Law		1993		7,749		10			7,749	19
20	Regrade Suface		1993		17,716		15			17,716	20
21	Gutter Downspout No.		1993		3,600		15			3,600	21
22	Concrete Walk		1994		1,225		20			1,225	22
23	Safety Door Shield		1994		1,250		10			1,250	23
24	Door Closers Safety		1995		4,432		15			4,432	24
25	Replace Sidewalks		1995		6,507		20			6,507	25
26	Vinyl Soffit		1995		4,100		20			4,100	26
27	Walks Drive Approach		1996		3,809		20			3,809	27
28	EFF Lighting Fixtures		1997		13,031		15			13,031	28
29	Radiant Heat Panels		1998		19,894		10			19,894	29
30	Kitchen Fire System		1998		898		20			898	30
31	Painting		1999		11,227		5			11,227	31
32	GFI Electric Update		2000		4,800		20			4,800	32
33	New South Roof		2002		171,935	5,731	30	5,731		133,248	33
34	New North Roof		2003		140,137	4,672	30	4,672		103,545	34
35	Bathroom Tile		2005		1,500		20	12	12	1,500	35
36											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

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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	Replacement of PVC & Clay Tiles	2005	\$ 1,153	\$ 39	30	\$ 39	\$	\$ 787	37
38	Exit/Cylinder Change Room Doors	2005	4,426	132	20	132		4,426	38
39	New Locks for half of the Resident Rooms	2006	2,897	145	20	145		2,838	39
40	Concrete Work	2006	2,595		15			2,595	40
41	Automatic Door for Courtyard	2006	2,665	134	20	134		2,553	41
42	Asphalt Half Circle driveway	2006	2,300		15			2,300	42
43	Metal Wall	2007	9,523	476	20	476		8,887	43
44	Carpet	2007	3,014		10			3,014	44
45	Fire Alarm Control Panel	2007	8,000		10			8,000	45
46	Smoke detectors horns/strobes	2007	8,763		10			8,763	46
47	Concrete Patio	2007	5,860	293	10	293		5,421	47
48	Actuator (Lifts) - 2	2007	1,072		10			1,072	48
49	IDPH Fire Improvements	2007	8,755	438	20	438		7,882	49
50	IDPH Fire Improvements-Door Frames	2008	19,090	955	20	955		17,186	50
51	IDPH Fire Improvements-Luse Thermal	2008	11,580	579	20	579		10,374	51
52	New Locks for Residents	2008	2,786	139	20	139		2,481	52
53	Smoke Detector Door Alarm Lite	2008	1,580		10			1,580	53
54	IDPH Fire Improvement-Rolling Fire	2008	10,247	513	20	513		9,049	54
55	Smoke Dectectors alarms	2008	1,300		10			1,300	55
56	Fire Dampers in Kitchen	2008	1,600	80	20	80		1,407	56
57	Glue down carpet cove bace	2008	806		10			806	57
58	New Roof	2008	100,676	3,541	30	3,356	(185)	58,171	58
59	Sliding Door	2008	5,940	297	10	297		5,148	59
60	New Carpet for Unit A	2008	806		10			806	60
61	Frames for Doors	2008	2,846		10			2,846	61
62	Doors & Drywall	2008	9,309	465	20	465		7,948	62
63	Fire Alarm Phase II	2008	3,200		10			3,200	63
64	Ceramic Tile for 2nd Floor Dining RM	2008	1,064		10			1,064	64
65	Fabricate & Install Railings on Stairways	2009	3,000		10			3,000	65
66	Fire System Update-Phase III	2009	4,553		10			4,553	66
67	Fire System Update-Phase III	2009	7,320		10			7,320	67
68	Stainless Steel Bench/Counter/Cabinets	2009	4,506		10			4,506	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,342,185	\$ 46,134		\$ 45,961	\$ (173)	\$ 3,008,670	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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:

1/1/2025

Ending:

12/31/2025

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,342,185	\$ 46,134		\$ 45,961	\$ (173)	\$ 3,008,670	1
2	Hollow Metal Door/Kitchen	2009	1,150		10			1,150	2
3	Kitchen Renovation	2009	18,257	1,081	20	913	(168)	15,521	3
4	Door-Life Safety Code	2009	4,680	234	20	234		3,744	4
5	Sidewalk-McKenney to Morgan on Brinton	2010	3,400	129	15	129		3,400	5
6	Steel Door/Frame-Soc.Serv.	2012	2,861		10			2,861	6
7	Automatic Sprinkler System	2012	140,225	7,011	20	7,011		97,571	7
8	Carpet-rooms 14,19 & 109-disposed	2012	3,674		5			3,674	8
9	PTACS	2012	22,296		10			22,296	9
10	Water Heater	2013	24,114		10			24,114	10
11	Washer	2013	7,539		5			7,539	11
12	Mixer Valve for Water Heater	2013	2,075		5			2,075	12
13	PTACS	2013	14,857					14,857	13
14	Wireless/Computers for HCC	2013	7,371		5			7,371	14
15	Heat/Cool Unit	2013	2,750		5			2,750	15
16	Concrete Sidewalk-North End	2013	6,775		5			6,775	16
17	Computer/Monitor for Activities/Programs	2013	1,181		5			1,181	17
18	Computer Administrator	2013	953		5			953	18
19	Tile-HCC Room	2013	1,323		5			1,323	19
20	Carpet Room - 11	2013	885		5			885	20
21	Generator Circuits	2013	7,984		5			7,984	21
22	MDS Software-PointClickCare	2013	15,929		5			15,929	22
23	Carpet-Room 5 SC	2013	931		5			931	23
24	Wireless Internet	2014	1,845		5			1,845	24
25	PC for HCC (Wireless w/Mount)	2014	710		5			710	25
26	VESA Mount Compatible PC	2014	885		5			885	26
27	Central Air (Kitchen)	2014	6,700		5			6,700	27
28	PTACs (13)-disposed	2014	19,447		5			19,447	28
29	Computer-MDS Coordinator	2014	750		5			750	29
30	Elevator Equipment	2014	6,005		5			6,005	30
31	Web Design	2014	1,222		5			1,222	31
32	Solid State Starter (Elevator)	2014	2,588		5			2,588	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,673,547	\$ 54,589		\$ 54,248	\$ (341)	\$ 3,293,706	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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:

1/1/2025

Ending:

12/31/2025

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		\$ 3,673,547	\$ 54,589		\$ 54,248	\$ (341)	\$ 3,293,706	1
2	<u>Reclining Tub/HCC</u>	2015	14,440		5			14,440	2
3	<u>Furnish/Install Magic Force (Door)</u>	2015	2,160	108	20	108		1,134	3
4	<u>Seal Coating</u>	2015	3,590		15	239	239	2,490	4
5	<u>New Door Knobs for Res. Doors</u>	2015	1,578	79	20	79		823	5
6	<u>Automatic Stanley Door</u>	2015	2,160	108	20	108		1,125	6
7	<u>Installed Emergency Light/Battery</u>	2015	3,085		5			3,085	7
8	<u>Heritage Square Sign</u>	2015	12,450	830	15	830		8,438	8
9	<u>Dining Room Tile/Carpet</u>	2015	40,053	5,507	10	3,340	(2,167)	40,053	9
10	<u>Repair HCC Balconey poured pad</u>	2015	4,690	313	15	313		3,155	10
11	<u>PTACs (11)-disposed</u>	2015	16,298		5			16,298	11
12	<u>Carpet</u>	2016	11,660		5			11,660	12
13	<u>Nursing Call System</u>	2016	143,580		5			143,580	13
14	<u>Tile Flooring-Nurses Station/Dining Room</u>	2016	18,475		5			18,475	14
15	<u>Carpet Rooms 6 & 17-disposed</u>	2017	2,003		10	200	200	1,784	15
16	<u>Carpets Rooms 37 & 38</u>	2017	1,303		5			1,303	16
17	<u>Removal of Oak Tree</u>	2017	1,200	60	20	60		530	17
18	<u>Flooring-Rooms 218 & 221</u>	2017	7,094	709	10	709		6,264	18
19	<u>Wainscoting with Deco cutouts</u>	2017	7,200	720	10	720		6,300	19
20	<u>Flooring-Room 223</u>	2017	2,659	266	10	266		2,328	20
21	<u>Tile/Vinyl for Room 202</u>	2017	3,802	380	10	380		3,294	21
22	<u>Flooring-Rooms 15, 40 & 46</u>	2017	2,438	244	10	244		2,093	22
23	<u>Cement parking bumpers</u>	2017	504	25	20	25		216	23
24	<u>Sidewalk/manhole upgrade</u>	2017	975	49	20	49		416	24
25	<u>Horn Strobes and Pull Station</u>	2017	1,936	194	10	194		1,648	25
26	<u>Carpet/Tile-Room 23</u>	2017	1,312	131	10	131		1,104	26
27	<u>Carpet for Room 3</u>	2017	1,198	120	10	120		999	27
28	<u>Surface Fire Rated Vertical Rod</u>	2017	2,614	261	10	261		2,176	28
29	<u>Tiling & Floor Covering - Room 20</u>	2018	4,071	407	10	407		3,086	29
30	<u>AHVAC/AC for Dining Room</u>	2018	5,950	595	10	595		4,512	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,994,025	\$ 65,695		\$ 63,626	\$ (2,069)	\$ 3,596,515	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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:

1/1/2025

Ending:

12/31/2025

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		\$ 3,994,025	\$ 65,695		\$ 63,626	\$ (2,069)	\$ 3,596,515	1
2	<u>Carpet-Room 31</u>	2018	956	96	10	96		719	2
3	<u>Floor Scrubber</u>	2018	2,348		5			2,348	3
4	<u>Carpet-Room 39</u>	2018	764	76	10	76		552	4
5	<u>Carpet-Room 18</u>	2018	724	72	10	72		523	5
6	<u>Carpet-Room 33 & 36</u>	2018	1,361	136	10	136		975	6
7	<u>Carpet-Room 13</u>	2018	664		10	66	66	469	7
8	<u>PT Room - Tiling around Bathtub</u>	2018	5,949	595	10	595		4,165	8
9	<u>2 HCC Laptops for Medical Records</u>	2019	1,116		5			1,116	9
10	<u>New Computers for Dietary w/Office 2019</u>	2019	850		5			850	10
11	<u>Dir. Of Nursing - Computer</u>	2019							11
12	<u>Nurse Call system-Software Update</u>	2019	4,980		5			4,980	12
13	<u>Carpet-Room 27</u>	2019	633		5			633	13
14	<u>PTAC (4)</u>	2019	1,570		5			1,570	14
15	<u>Lift w/Scale</u>	2019	4,382		5			4,382	15
16	<u>Computer/Software-Bookkeeper</u>	2019	1,145		5			1,145	16
17	<u>Physical Therapy Room-Painting</u>	2019	7,063		5			7,063	17
18	<u>ASUS VivoBook2-(Req.Electronic Med. Records)</u>	2019	1,330		5			1,330	18
19	<u>New Alarm System-SC</u>	2019	15,780		5			15,780	19
20	<u>2nd payment - eMar/Pharmacy</u>	2019	2,400		5			2,400	20
21	<u>New Flooring for quest diningroom</u>	2019	4,065		5			4,065	21
22	<u>Security Eqpt. For Building</u>	2019	9,012		5			9,012	22
23	<u>Gov't approved Tar Sealer, parking lot</u>	2019	2,836	189	15	189		1,166	23
24	<u>Wireless Upgrade for EMR</u>	2019	1,300		5			1,300	24
25	<u>Install New Dryer</u>	2019	418	42	10	42		259	25
26	<u>Hopper Room</u>	2020	2,359	236	10	236		1,396	26
27	<u>Shower Hall Security System</u>	2020	1,090	109	10	109		645	27
28	<u>Security System</u>	2020	7,438	123	5	123		7,438	28
29	<u>Carpet-Room 14</u>	2020	1,252	125	10	125		730	29
30	<u>Handrail by Garage</u>	2020	2,840	284	10	284		1,633	30
31	<u>Stainless Count Top/Cover Wood</u>	2020	1,999	200	10	200		1,150	31
32	<u>SC Treatment Room-Upgrade Tile</u>	2020	1,803	180	10	180		990	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,084,452	\$ 68,158		\$ 66,155	\$ (2,003)	\$ 3,677,299	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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:

1/1/2025

Ending:

12/31/2025

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 12D, Carried Forward		\$ 4,084,452	\$ 68,158		\$ 66,155	\$ (2,003)	\$ 3,677,299	1
2	50% on Fire Door	2020	3,419	341	5	341		3,419	2
3	Fire Door (2nd Payment)	2020	3,419	398	5	398		3,419	3
4	Flooring Room 204	2020	2,900	290	10	290		1,571	4
5	Rollup Generator Quick Connect	2020	12,045	1,606	5	1,606		12,045	5
6	Upgraded Telligence (Nurse Call System)	2020	2,400	320	5	320		2,400	6
7	Carpet for Rm 14	2021	2,028	203	10	203		930	7
8	Tile & Flooring Rm 223	2021	6,294	629	10	629		2,883	8
9	Replace Sewer Line/Concrete in Basement	2022	15,285	764	20	764		2,547	9
10	7 New PTAC Units	2022	7,882	1,577	5	1,577		5,605	10
11	Install New Water Softener	2023	19,524	976	20	976		2,766	11
12	Repair Nurse Call System	2023	4,196		20	210	210	525	12
13	Repair AC Unit and Freon/Coil Cleaner	2024	3,117		5	623	623	935	13
14	Install New AC Compressor/ Liquid Line Drier/Recharge Unit	2024	2,629		5	526	526	789	14
15	Parking Lot-Fill Cracks/One Coat Asphalt Sealer/Restripe	2024	3,152		10	315	315	473	15
16	2 New PTAC Units	2024	3,240		5	648	648	972	16
17	New 10-Ton RTU/Curb Adapter/Economizer/CO2 Sensor	2025	15,550	1,555	10	1,555		1,555	17
18	Replace AC in Living Room Area/SC	2025	8,500	425	10	425		425	18
19	Install New Retaining Wall/Stone/Shrubs	2025	5,983	100	10	100		100	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29	Additional Book Depreciation			2,916			(2,916)		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,206,015	\$ 80,258		\$ 77,661	\$ (2,597)	\$ 3,720,658	34

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$132,783	\$14,256	\$13,304	\$(952)	3-20 yrs	\$105,680	71
72	Current Year Purchases	14,100	1,075	943	(132)	10 yrs	943	72
73	Fully Depreciated Assets	384,764					384,764	73
74								74
75	TOTALS	\$531,647	\$15,331	\$14,247	\$(1,084)		\$491,387	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	2015-Impala LT-Disposed 2025	2021	\$	\$966	\$966	\$	5	\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$966	\$966	\$		\$	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)	\$4,811,865	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$96,555	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$92,874	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(3,681)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,212,045	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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: N/A
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
- N/A
N/A
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?
16. Rental Amount for movable equipment: \$ 1,482 Description: Miscellaneous
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2024 GMC Terrain	\$ 609.66	\$ 4,902	17
18					18
19					19
20					20
21	TOTAL		\$ 609.66	\$ 4,902	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.)

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)	\$			

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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): <u>Laboratory Expense</u>	39(3)				5,368			5,368	12
13	Other (specify): <u></u>									13
14	TOTAL			\$		\$ 5,368	\$		\$ 5,368	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 272,114	\$ 272,114	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 124,580)	86,916	86,916	3
4	Supply Inventory (priced at Cost)	42,326	42,326	4
5	Short-Term Investments			5
6	Prepaid Insurance	34,664	34,664	6
7	Other Prepaid Expenses	13,643	13,643	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 449,663	\$ 449,663	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,151,004	1,151,004	12
13	Land	74,203	74,203	13
14	Buildings, at Historical Cost	2,632,280	2,632,280	14
15	Leasehold Improvements, at Historical Cost	1,492,697	1,573,735	15
16	Equipment, at Historical Cost	596,732	531,647	16
17	Accumulated Depreciation (book methods)	(4,190,031)	(4,212,045)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,551,690	1,551,690	21
22	Other Long-Term Assets (spec In Perpetual Trust	7,689,735	7,689,735	22
23	Other(specify): R.L. Warner Campus	118,305	118,305	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,116,615	\$ 11,110,554	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,566,278	\$ 11,560,217	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 49,469	\$ 49,469	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	209,918	209,918	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	Accrued Exp/Payroll Withholdings	16,401	16,401	36
37	Due to Warner Campus	477	477	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 276,265	\$ 276,265	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)	\$ 276,265	\$ 276,265	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,290,013	\$ 11,283,952	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,566,278	\$ 11,560,217	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$11,915,521	1
2	Restatements (describe):		2
3	Post Closing Adjustments - See Attached Schedule 18A	(263,494)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$11,652,027	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(362,014)	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)	\$(362,014)	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)	\$11,290,013	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:Heritage Square

IDPH License ID Number:0018176

Fiscal Year End:12/31/2025

Schedule 18A

XVI. STATEMENT OF CHANGES IN EQUITY

Line 3 Restatements:

Description	Amount
Revenue Adjustment	(26,001)
Bad Debt Expense	(130,124)
Investment - FMV Adjustment	(67,385)
Accounts Payable Adjustments:	
General Services	(36,134)
Nursing	(559)
Gen Admin	(3,291)
Total - Line 3	(263,494)

Facility Name & ID Number Heritage Square

0018176

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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	\$ 4,009,009	1
2	Discounts and Allowances for all Levels	(33,856)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,975,153	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	420	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 420	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	7,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	950	13
14	Non-Patient Meals	1,284	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	34,375	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 43,609	23
	D. Non-Operating Revenue		
24	Contributions	261,143	24
25	Interest and Other Investment Income***	956,771	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,217,914	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	770	27
28	Miscellaneous Income	776	28
28a	QIP Income	4,133	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,679	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,242,775	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,561,465	31
32	Health Care	2,312,859	32
33	General Administration	1,130,150	33
	B. Capital Expense		
34	Ownership	102,939	34
	C. Ancillary Expense		
35	Special Cost Centers	403,545	35
36	Provider Participation Fee	93,831	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,604,789	40
41	Income before Income Taxes (line 30 minus line 40)**	(362,014)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (362,014)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 18,076.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer	164,896.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	3,792,181.00	48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,975,153	56

SEE ACCOUNTANTS' PREPARATION REPORT

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	2,080	2,080	\$ 106,635	\$ 51.27	1
2	Assistant Director of Nursing	1,307	1,410	54,789	38.86	2
3	Registered Nurses	8,953	9,542	337,344	35.35	3
4	Licensed Practical Nurses	11,590	11,853	345,971	29.19	4
5	CNAs & Orderlies	53,167	55,410	1,054,759	19.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	39,434	18.96	9
10	Activity Assistants	5,735	6,051	99,745	16.48	10
11	Social Service Workers	4,082	4,114	83,178	20.22	11
12	Dietician					12
13	Food Service Supervisor	1,800	1,846	47,788	25.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,908	24,941	423,498	16.98	15
16	Dishwashers					16
17	Maintenance Workers	3,934	4,288	114,827	26.78	17
18	Housekeepers	12,377	12,818	212,442	16.57	18
19	Laundry	4,160	4,397	80,360	18.28	19
20	Administrator	2,080	2,080	123,338	59.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,091	2,091	46,421	22.20	23
24	Clerical	5,200	5,517	110,409	20.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care MDS Coordinator	2,217	2,324	89,201	38.38	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,761	152,842	\$ 3,370,139 *	\$ 22.05	34

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	Monthly	\$ 3,096	L1, C3	35
36	Medical Director	Monthly	1,450	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	18	438	L10, C3	38
39	Pharmacist Consultant	52	2,340	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	2,518	L11, C3	44
45	Social Service Consultant	26	2,070	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	126	\$ 11,912		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Facility Name & ID Number

Heritage Square

STATE OF ILLINOIS

0018176

Report Period Beginning:

1/1/2025

Page 21

Ending:

12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Dan Howard

Administrator

0

\$ 123,338

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 123,338

B. Administrative - Other

Description

Amount

N/A

\$

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

Sikich

Audit/CPA

\$ 24,642

Templin Healthcare Accounting

Cost Report Preparation

2,932

Ehrmann Gehlbach Badger & Consid

Legal Services

2,118

PointClickCare Technologies

Data Processing

23,359

DC Computers

Computer Services

12,737

Paylocity

Payroll Service

27,126

Paychex

Payroll Service

273

Cira Richardson

Grant Work

1,011

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 94,198

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 41,972

Unemployment Compensation Insurance

FICA Taxes

254,241

Employee Health Insurance

272,062

Employee Meals

Illinois Municipal Retirement Fund (IMRF)*

Other Employee Benefits

1,721

TOTAL (agree to Schedule V, line 22, col.8)

\$ 569,996

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

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 2,046

Advertising: Employee Recruitment

1,212

Health Care Worker Background Check

(Indicate # of checks performed 12)

866

Patient Background Checks

47

Association Dues (total from pg 22, #4)

Licenses & Fees

295

Dues & Subscriptions

20

Less: Public Relations Expense

(745)

PAC and Lobbying payments

()

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 3,894

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

4,017

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$ 4,017

* Attach copy of IMRF notifications

SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

	Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 17,820 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 93,831

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 653
- (12)

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.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

100% Line 14

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.

\$ N/A
- (13)

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

Firm Name: Sikich LLP

Yes
- (14)

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

Yes
- (15)

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.