		FOR BHF USE					

LL1

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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0048157

Facility Name: Heritage Health Bloomington

Address: 700 East Walnut St (Number) Bloomington (City) 61701 (Zip Code)

County: McLean

Telephone Number: (309)827-8044 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2006

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		xx	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David M Underwood **Telephone Number:** (309)8237135
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 1/1/2020 to 12/31/2020 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) David M Underwood
(Title) EVP & CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(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 Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,208	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,208	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,894	13,144	2,846	21,884	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,894	13,144	2,846	21,884	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.95%

D. How many bed reserve days during this year were paid by the Department?
None (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)
None

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 [xx]

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

I. On what date did you start providing long term care at this location?
Date started 7/2006

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

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 88 and days of care provided 2,846

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	285,305	30,306	5,760	321,371		321,371	4,294	325,665			1
2	Food Purchase		247,953		247,953		247,953	(15)	247,938			2
3	Housekeeping	89,253	37,829		127,082		127,082	5,724	132,806			3
4	Laundry	81,139	15,946		97,085		97,085	409	97,494			4
5	Heat and Other Utilities			107,683	107,683		107,683	1,363	109,046			5
6	Maintenance	110,485	79,059	123,619	313,163		313,163	16,705	329,868			6
7	Other (specify):*											7
8	**TOTAL General Services**	566,182	411,093	237,062	1,214,337		1,214,337	28,480	1,242,817			8
	B. Health Care and Programs											
9	Medical Director			35,331	35,331		35,331		35,331			9
10	Nursing and Medical Records	2,530,801	218,578	23,194	2,772,573	(3,752)	2,768,821	8,297	2,777,118			10
10a	Therapy		317,512	55,756	373,268	(369,516)	3,752		3,752			10a
11	Activities	76,594	1,525		78,119		78,119	5	78,124			11
12	Social Services	58,252		381	58,633		58,633	123	58,756			12
13	CNA Training	4,306	4,282		8,588		8,588		8,588			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,669,953	541,897	114,662	3,326,512	(373,268)	2,953,244	8,425	2,961,669			16
	C. General Administration											
17	Administrative	95,906			95,906		95,906		95,906			17
18	Directors Fees											18
19	Professional Services			368,615	368,615		368,615	(350,640)	17,975			19
20	Dues, Fees, Subscriptions & Promotions			207,350	207,350	(168,352)	38,998	(21,733)	17,265			20
21	Clerical & General Office Expenses	428,377	31,968	14,640	474,985		474,985	366,311	841,296			21
22	Employee Benefits & Payroll Taxes			718,622	718,622		718,622	36,889	755,511			22
23	Inservice Training & Education			1,233	1,233		1,233	1,160	2,393			23
24	Travel and Seminar			880	880		880	4,119	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,600	52,600		52,600	61,111	113,711			26
27	Other (specify):* Lost resident items			(35,418)	(35,418)		(35,418)	35,786	368			27
28	**TOTAL General Administration**	524,283	31,968	1,328,522	1,884,773	(168,352)	1,716,421	133,003	1,849,424			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,760,418	984,958	1,680,246	6,425,622	(541,620)	5,884,002	169,908	6,053,910			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Health Bloomington #0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							440,291	440,291			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,755	42,755		42,755	157,684	200,439			32
33	Real Estate Taxes							93,254	93,254			33
34	Rent-Facility & Grounds			486,180	486,180		486,180	(486,977)	(797)			34
35	Rent-Equipment & Vehicles			45,521	45,521		45,521	11,255	56,776			35
36	Other (specify):*											36
37	**TOTAL Ownership**			574,456	574,456		574,456	215,507	789,963			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			421,402	421,402	373,268	794,670	136,509	931,179			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					168,352	168,352		168,352			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			421,402	421,402	541,620	963,022	136,509	1,099,531			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,760,418	984,958	2,676,104	7,421,480		7,421,480	521,924	7,943,404			45

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(7,155)			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	(109)			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	(5,318)			17
18	Fines and Penalties				18
19	Entertainment	(462)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,897)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	35,786			24
25	Fund Raising, Advertising and Promotional	(17,260)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (415)		$	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)	522,339		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 522,339		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 521,924		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

Heritage Health Bloomington

ID# 0048157

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11		(5,897)	19	11
12		(109)	32	12
13		35,786	27	13
14		(17,260)	20	14
15		(5,318)	20	15
16		0	27	16
17		(462)	24	17
18		(7,155)	34	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**	(415)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	4,294	0	0	0	0	0	0	0	0	4,294	1
2	Food Purchase	0	0	(15)	0	0	0	0	0	0	0	0	(15)	2
3	Housekeeping	0	0	5,724	0	0	0	0	0	0	0	0	5,724	3
4	Laundry	0	0	409	0	0	0	0	0	0	0	0	409	4
5	Heat and Other Utilities	0	0	1,363	0	0	0	0	0	0	0	0	1,363	5
6	Maintenance	0	0	16,705	0	0	0	0	0	0	0	0	16,705	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	28,480	0	0	0	0	0	0	0	0	28,480	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	(13,937)	22,234	0	0	0	0	0	0	0	0	8,297	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	5	0	0	0	0	0	0	0	0	5	11
12	Social Services	0	0	123	0	0	0	0	0	0	0	0	123	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**	0	(13,937)	22,362	0	0	0	0	0	0	0	0	8,425	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	(5,897)	(359,317)	14,574	0	0	0	0	0	0	0	0	(350,640)	19
20	Fees, Subscriptions & Promotions	(22,578)	0	845	0	0	0	0	0	0	0	0	(21,733)	20
21	Clerical & General Office Expenses	0	0	366,311	0	0	0	0	0	0	0	0	366,311	21
22	Employee Benefits & Payroll Taxes	0	0	36,889	0	0	0	0	0	0	0	0	36,889	22
23	Inservice Training & Education	0	0	1,160	0	0	0	0	0	0	0	0	1,160	23
24	Travel and Seminar	(462)	0	4,581	0	0	0	0	0	0	0	0	4,119	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	61,111	0	0	0	0	0	0	0	0	61,111	26
27	Other (specify):*	35,786	0	0	0	0	0	0	0	0	0	0	35,786	27
28	**TOTAL General Administration**	6,849	(359,317)	485,471	0	0	0	0	0	0	0	0	133,003	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	6,849	(373,254)	536,313	0	0	0	0	0	0	0	0	169,908	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heritage Health Bloomington **#** 0048157 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	419,642	0	20,649	0	0	0	0	0	0	0	440,291	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(109)	155,475	0	2,318	0	0	0	0	0	0	0	157,684	32
33	Real Estate Taxes	0	93,254	0	0	0	0	0	0	0	0	0	93,254	33
34	Rent-Facility & Grounds	(7,155)	(486,180)	0	6,358	0	0	0	0	0	0	0	(486,977)	34
35	Rent-Equipment & Vehicles	0	0	0	11,255	0	0	0	0	0	0	0	11,255	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,264)	182,191	0	40,580	0	0	0	0	0	0	0	215,507	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	136,344	0	165	0	0	0	0	0	0	0	136,509	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	136,344	0	165	0	0	0	0	0	0	0	136,509	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(415)	(54,719)	536,313	40,745	0	0	0	0	0	0	0	521,924	45

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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
Center SNF Services LLC	100	Attached Following This Page		Heritage Operations G	Bloomington	Mgmt. Services
				Green Tree Pharmacy	Minonk	Pharmacy
				Heritage Manor Real E	Bloomington	Propert rental

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. [xx] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Adjustment for Related Organiza	$	GreenTree Pharmacy		$ (13,937)	$ (13,937)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy				2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		136,344	136,344	3
4	V	19	Adjustment for Related Organization	359,317	Heritage Operations Group, LLC			(359,317)	4
5	V								5
6	V	34	Adjustment for Related Organization	486,180	Heritage Manor Real Estate, LLC			(486,180)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		93,254	93,254	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		146,650	146,650	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		419,642	419,642	9
10	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		8,825	8,825	10
11	V								11
12	V								12
13	V								13
14	Total			$ 845,497			$ 790,778	$ * (54,719)	14

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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. [xx] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Operations Group		$ 4,294	$ 4,294	15
16	V	2	Food Purchase		Heritage Operations Group		(15)	(15)	16
17	V	3	Housekeeping		Heritage Operations Group		5,724	5,724	17
18	V	4	Laundry		Heritage Operations Group		409	409	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,363	1,363	19
20	V	6	Maintenance		Heritage Operations Group		16,705	16,705	20
21	V	7	Other		Heritage Operations Group		0		21
22	V	9	Medical Director		Heritage Operations Group		0		22
23	V	10	Nursing & Medical Records		Heritage Operations Group		22,234	22,234	23
24	V	11	Activities		Heritage Operations Group		5	5	24
25	V	12	Social Service		Heritage Operations Group		123	123	25
26	V	13	Nurse Aide Training		Heritage Operations Group		0		26
27	V	14	Program Transportation		Heritage Operations Group		0		27
28	V	15	Other		Heritage Operations Group		0		28
29	V	17	Administrative		Heritage Operations Group		0		29
30	V	18	Directors Fees		Heritage Operations Group		0		30
31	V	19	Professional Services		Heritage Operations Group		14,574	14,574	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		845	845	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		366,311	366,311	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		36,889	36,889	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,160	1,160	35
36	V	24	Travel and Seminar		Heritage Operations Group		4,581	4,581	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		61,111	61,111	38
39	Total			$			$ 536,313	$ * 536,313	39

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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. [xx] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27		$	Heritage Operations Group		$ 0	$	15
16	V	30			Heritage Operations Group		20,649	20,649	16
17	V	31			Heritage Operations Group		0		17
18	V	32			Heritage Operations Group		2,318	2,318	18
19	V	33			Heritage Operations Group		0		19
20	V	34			Heritage Operations Group		6,358	6,358	20
21	V	35			Heritage Operations Group		11,255	11,255	21
22	V	36			Heritage Operations Group		0		22
23	V	38			Heritage Operations Group		0		23
24	V	39			Heritage Operations Group		165	165	24
25	V	40			Heritage Operations Group		0		25
26	V	41			Heritage Operations Group		0		26
27	V	42			Heritage Operations Group		0		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 40,745	$ * 40,745	39

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Center SNF Services LLC			100.00	0	0			$ 0		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 Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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 [xx] NO [ ]

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

Name of Related Organization: Heritage Operations Group
Street Address: 115 W Jefferson Street
City / State / Zip Code: Bloomington, IL 61701
Phone Number: (309 828-4361
Fax Number: (309 829-5477

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,493	25	$ 121,634	$ 121,338	88	$ 4,294	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	88	(15)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	88	5,724	3
4	4	Laundry	Beds	2,493	25	11,591	0	88	409	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	88	1,363	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	88	16,705	6
7	7	Other	Beds	2,493	25	0	0	88	0	7
8	9	Medical Director	Beds	2,493	25	0	0	88	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	88	22,234	9
10	11	Activities	Beds	2,493	25	129	0	88	5	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	88	123	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	88	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	88	0	13
14	15	Other	Beds	2,493	25	0	0	88	0	14
15	17	Administrative	Beds	2,493	25	0	0	88	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	88	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	88	14,574	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	88	845	18
19	21	Clerical & General Office Expens	Beds	2,493	25	10,377,428	9,978,005	88	366,311	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,493	25	1,045,059	0	88	36,889	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	88	1,160	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	88	4,581	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	88	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	88	61,111	24
25	TOTALS					$ 15,193,470	$ 10,226,789		$ 536,313	25

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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 [xx] NO [ ]

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

Name of Related Organization: Heritage Operations Group
Street Address: 115 W Jefferson Street
City / State / Zip Code: Bloomington, IL 61701
Phone Number: (309 828-4361
Fax Number: (309 829-5477

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,493	25	$	$	88	$	1
2	30	Depreciation	Beds	2,493	25	584,981		88	20,649	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			88		3
4	32	Interest	Beds	2,493	25	65,658		88	2,318	4
5	33	Real Estate Taxes	Beds	2,493	25			88		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		88	6,358	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		88	11,255	7
8	36	Other	Beds	2,493	25			88		8
9	38	Medically Nec Transportation	Beds	2,493	25			88		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		88	165	10
11	40	Barber and Beauty Shops	Beds	2,493	25			88		11
12	41	Coffee and Gift Shops	Beds	2,493	25			88		12
13	42	Other	Beds	2,493	25			88		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					$ 1,154,273	$		$ 40,745	25

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Busey Bank		xx	Mortgage			$	$			$ 146,650	1
2	Busey Bank		xx	Loan Fee Amortization							8,825	2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		xx	Working Capital							42,755	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 198,230	9
	B. Non-Facility Related*											
10	Interest Income										(109)	10
11												11
12	Allocated Corporate										2,318	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,209	14
15	TOTALS (line 9+line14)						$	$			$ 200,439	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line #

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

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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.)	$	93,254	2
3. Under or (over) accrual (line 2 minus line 1).	$	93,254	3
4. Real Estate Tax accrual used for 2020 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.	$	93,254	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2015	89,239	8
2016	86,696	9
2017	89,368	10
2018	86,515	11
2019	93,254	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Health Bloomington COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0048157

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	2104227013		$ 93,254.00	$ 93,254.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 93,254.00	$ 93,254.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,544 B. General Construction Type: Exterior Brick Frame Wood Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [xx] (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 [xx] (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).

None

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1988	$ 116,576	1
2			2010	138,502	2
3	TOTALS			$ 255,078	3

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88				$ 560,548	$		$	$	$	4
5					221,147						5
6											6
7											7
8											8
	Improvement Type**										
9	1978 Improvements			1978	14,607						9
10	1979 Improvements			1979	95,460						10
11	1980 Improvements			1980	75,591						11
12	1981 Improvements			1981	11,544						12
13	1982 Improvements			1982	9,256						13
14	1983 Improvements			1983	13,130						14
15	1984 Improvements			1984	7,215						15
16	1985 Improvements			1985	45,885						16
17	1986 Improvements			1986	13,469						17
18	1988 Improvements			1988	83,109						18
19	1989 Improvements			1989	2,439						19
20	1990 Improvements			1990	30,676						20
21	1991 Improvements			1991	4,207						21
22	1992 Improvements			1992	1,208						22
23	1993 Improvements			1993	97,303						23
24	1994 Improvements			1994	29,638						24
25	1995 Improvements			1995	121,304						25
26	1996 Improvements			1996	126,219						26
27	1997 Improvements			1997	259,216						27
28	1998 Improvements			1998	132,949						28
29	1999 Improvements			1999	1,196,674						29
30	2000 Improvements			2000	34,981						30
31	2001 Improvements			2001	14,059						31
32	2002 Improvements			2002	27,818						32
33											33
34	C/O Allocation					20,649		20,649			34
35	Book Depreciation					398,161		398,161			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.

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	
37	2003 Improvements	2003	$ 149,528	$		$	$	$	37
38	2004 Improvements	2004	20,458						38
39	2005 Improvements	2005	18,640						39
40	2006 Improvements	2006	76,415						40
41	2007 Improvements	2007	29,101						41
42	2008 Improvements	2008	99,600						42
43	2009 Improvements	2009	521,032						43
44	2010 Improvements	2010	109,588						44
45	2011 Improvements	2011	4,558,590						45
46	2012 Improvements	2012	191,018						46
47	2013 Improvements	2013	23,056						47
48	2014 Improvements	2014	56,999						48
49									49
50	Install (6) PTAC units	2015	2,730						50
51	Replaced east dining room compressor	2015	3,685						51
52	Replace sewage ejection pump	2015	4,406						52
53									53
54	Install 5T condensing unit	2016	3,802						54
55									55
56	Replaced shower room floor	2017	4,993						56
57	Partial roof replacement	2017	23,889						57
58	Replaced hot water pump	2017	2,998						58
59									59
60	Replace vertical expansion tank and ball valves	2018	3,250						60
61	Replace carpet throughout facility	2018	80,561						61
62	Replace AC wall units	2018	3,384						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,217,375	$ 418,810		$ 418,810	$	$	70

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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		$ 9,217,375	$ 418,810		$ 418,810	$	$	1
2									2
3	Install (2) mini-split HVAC units	2019	10,425						3
4	Construct new exterior retaining walls	2019	35,000						4
5	Replace compressor - East dining room	2019	4,810						5
6	Install Uni-Fit 10K unit	2019	3,092						6
7	Replace fire alarm remote test switches	2019	3,017						7
8									8
9	Upgrade fire sprinkler and fire wall as part of Plan of Correction	2020	18,873						9
10	Replace water boiler	2020	10,782						10
11	Epoxy front steps to facilitye	2020	6,129						11
12	Replace radiator on generator	2020	3,346						12
13	Repalce West Entrance door	2020	6,113						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	TOTAL (lines 1 thru 33)		$ 9,318,962	$ 418,810		$ 418,810	$	$	34

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 2,306,344	$ 21,481	$ 21,481	$		$	71
72	Current Year Purchases	35,263						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,341,607	$ 21,481	$ 21,481	$		$	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 11,915,647	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 440,291	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 440,291	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)	$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

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 [xx] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [xx] NO

16. Rental Amount for movable equipment: $ 45,521 Description: Office equipment and televisions
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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		4,282		4,282
3	Classroom Wages (a)				
4	Clinical Wages (b)		4,306		4,306
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 8,588	$	$ 8,588
10	SUM OF line 9, col. 1 and 2 (e)	$ 8,588			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	$		$ 156,448	$		$ 156,448	1
2	Licensed Speech and Language Development Therapist		hrs			38,442			38,442	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			226,512	0		226,512	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				317,512		317,512	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					55,756			55,756	13
14	TOTAL			$		$ 477,158	$ 317,512		$ 794,670	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.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 400	$	1
2	Cash-Patient Deposits	14,564		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	82,795		3
4	Supply Inventory (priced at FIFO)	12,753		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,807		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,391,182)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (1,278,863)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (1,278,863)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,564		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	260,580		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,888		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	Bed Tax	8,941		36
37	Deferred Stimulus	203,730		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 500,703	$	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)**	$ 500,703	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,779,566)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (1,278,863)	$	48

*(See instructions.)

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,635,991)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,635,991)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(143,575)	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)**	$ (143,575)	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)**	$ (1,779,566)	24 *

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,672,424	1
2	Discounts and Allowances for all Levels	(2,144,228)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,528,196	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,648,467	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,648,467	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	493,624	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	883	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	7,155	16
17	Sale of Drugs	598,552	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(61)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,100,153	23
	D. Non-Operating Revenue		
24	Contributions	980	24
25	Interest and Other Investment Income***	109	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,089	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,277,905	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,214,337	31
32	Health Care	3,326,512	32
33	General Administration	1,884,773	33
	B. Capital Expense		
34	Ownership	574,456	34
	C. Ancillary Expense		
35	Special Cost Centers	421,402	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,421,480	40
41	**Income before Income Taxes (line 30 minus line 40)****	(143,575)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (143,575)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		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)	$	49

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

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

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

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

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,138	2,227	$ 88,336	$ 39.67	1
2	Assistant Director of Nursing	1,935	2,016	67,368	33.42	2
3	Registered Nurses	22,114	23,035	772,132	33.52	3
4	Licensed Practical Nurses	14,405	15,005	411,913	27.45	4
5	CNAs & Orderlies	73,004	76,046	1,153,138	15.16	5
6	CNA Trainees	453	472	4,306	9.12	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,070	2,156	37,914	17.59	8
9	Activity Director					9
10	Activity Assistants	6,150	6,406	76,594	11.96	10
11	Social Service Workers	2,801	2,918	58,252	19.96	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,992	22,908	285,305	12.45	15
16	Dishwashers					16
17	Maintenance Workers	5,830	6,072	110,485	18.20	17
18	Housekeepers	7,335	7,640	89,253	11.68	18
19	Laundry	5,983	6,232	81,139	13.02	19
20	Administrator	1,992	2,075	95,906	46.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,830	17,531	428,377	24.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	185,032	192,739	$ 3,760,418 *	$ 19.51	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,760	L1 C3	35
36	Medical Director		35,331	L9 C3	36
37	Medical Records Consultant		865	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,752	L10A 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				44
45	Social Service Consultant		381	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 46,089		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 17,996	L10 C3	50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		0		52
53	TOTAL (lines 50 - 52)		$ 17,996		53

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Holifield	Administrator		$ 95,906
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,906

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Management	$ 362,718
Legal adj to Zero		5,897
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 368,615

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,731
Unemployment Compensation Insurance	12,757
FICA Taxes	287,672
Employee Health Insurance	247,379
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	131,083
Central Office Allocation	36,889
TOTAL (agree to Schedule V, line 22, col.8)	$ 755,511

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	$
Advertising: Employee Recruitment	3,905
Health Care Worker Background Check	
(Indicate # of checks performed)	4,125
Patient Background Checks	
PR	6,663
Dues & Subscriptions	8,050
License & Fees	5,658
Central Office Allocation	845
Less: Public Relations Expense	(6,663)
Non-allowable advertising	(5,318)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,265

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	365
	0
Seminar Expense	515
	4,119
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Health Bloomington # 0048157 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI - $3,960**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **168,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **326**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
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? **NA**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **MCK CPA's & Advisors**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **None Claimed**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number		Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount	
1009		PETTY CASH	400						
1010		CASH IN BANK							
1040		CASH IN BANK-PAYROLL							
1100		ACCOUNTS RECEIVABLE	82,795						
1110		MEDICARE RECEIVABLES							
1125		IPA INCOME RECEIVABLE							
1130		MEDICARE COST REPORT							
1132		US HHS STIMULUS SETTLEME	-203,730						
1140		UNAPPLIED CASH RECEIPTS							
1145		A/R SUSPENSE-REFUNDS							
1190		ACCRUED INTEREST REC							
1200		PREPAID INSURANCE	1,807						
1220		OTHER PREPAID EXPENSES							
1300		FOOD INVENTORY	12,753						
1310		SUPPLIES INVENTORY							
1409		LAND	0						
1450		FURNITURE & EQUIPMENT	0						
1460		ACCUM DEPR-FURN & EQUIP	0						
1475		BUILDING & IMPROVEMENTS	0						
1490		ACCUM DEPR-BUILDING	0						
1530		RESIDENT FUNDS	14,564						
1550		LOAN FEES	0						
1560		REAL ESTATE TAX ESCROW							
1575		REIMBURSABLE PURCHASES							
1850		INTRACOMPANY	-1,391,182						
2010		ACCOUNTS PAYABLE	0						
2095		BONUSES PAYABLE							
2100		ACCRUED PAYROLL	-54,951						
2110		ACCRUED VACATION PAY	-205,629						
2120		UC TAXES PAYABLE							
2125		FICA TAX PAYABLE	-12,888	-12,888					
2130		FIT PAYABLE							
2140		STATE W/H PAYABLE		0					
2145		EARNED INCOME CREDIT							
2150		UC FED CREDIT REDUCTION							
2230		PAYROLL SAVINGS							
2235		IRA W/HOLDINGS							
2240		UNITED WAY							
2245		GROUP INSURANCE PAYABLE							
2246		GROUP INSURANCE PAYABLE-CAFETERIA							
2260		WAGE GARNISHMENTS							
2280		MISC PAYROLL DEDUCTIONS							
2300		ACCRUED INTEREST PAYABLE	0						
2310		SALES TAX PAYABLE							
2320		IPA PAYMENTS PAYABLE	-8,941						
2350		REAL ESTATE TAX PAYABLE	0						
2385		ACTIVITY FUND	0						
2390		SECURITY DEPOSITS	0						
2391		VOLUNTEER FUND							
2393		HEART FUND/BAZAAR							
2395		DEFERRED INC EMP & MEM							
2400		CURRENT PORTION LT DEBT							
2460		INCOME TAXES PAYABLE							
2512		DUE TO RESIDENTS	-14,564						
2600		MORTGAGE PAYABLE	0						
2650		EQUIPMENT LOAN PAYABLE							
2695		CURRENT PORTION LT DEBT							
2696		DEFERRED INCOME TAXES							
2710		COMMON STOCK							
2720		RETAINED EARNINGS	1,635,991						
2970		PROFIT/LOSS FOR PERIOD	143,575						
3007.1		PATIENT DAYS-PRIVATE	13,144						
3007.2		PATIENT DAYS-IPA	5,894						
3007.3		PATIENT DAYS-MEDICARE	2,846						
3007.4		PATIENT DAYS-CONVERSION							
3007.5		PATIENT DAYS-LICENSED							
3007.6		PATIENT DAYS-TOTAL							
3010	1	BASIC CHARGE-PRIVATE & VA	-6,644,862		0	0	0	0	
3015	1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0	
3020	1	BASIC CHARGE-IPA	0		0	0	0	0	
3030	1	BASIC CHARGE-MEDICARE	0		0	0	0	0	
3035	4	DAY CARE/HOME CARE			0	0	0	0	
3040	1	LIGHT NURSING CARE	0		0	0	0	0	
3050	1	MEDIUM NURSING CARE			0	0	0	0	
3060	1	HEAVY NURSING CARE			0	0	0	0	
3061	1	SKILLED NURSING CARE							
3080	1	NURSING SUPPLIES-PRIVATE	-12,494		0	0	0	0	
3081	1	NURSING SUPPLIES-IPA			0	0	0	0	
3082	1	NURSING SUPPLIES MED PT A			0	0	0	0	
3083	1	NURSING SUPPLIES MED PT B							
3100	17	DRUGS	-598,552		0	0	0	0	
3101	17	DRUGS-OTHER							
3110	6	PT-PRIVATE	-1,648,467		0	0	0	0	
3111	6	PT-IPA			0	0	0	0	
3112	6	PT-MEDICARE PART A			0	0	0	0	
3113	6	PT-MEDICARE PART B			0	0	0	0	
3130	1	PUBLIC AID ASSESSMENT INC	120,040						
3140	19	LABORATORY INCOME			0	0	0	0	
3150	6	SPEECH/OT-PRIVATE			0	0	0	0	
3151	6	SPEECH/OT-IPA			0	0	0	0	
3152	6	SPEECH/OT-MED PART A			0	0	0	0	
3153	6	SPEECH/OT MED PART B							
3410	2	IPA DISCOUNTS	2,144,228		0	0	0	0	
3411	2	MEDICAID PART B DISCOUNT			0	0	0	0	
3420	2	MEDICARE DISCOUNTS			0	0	0	0	
3452	10	HHS STIMULUS REVENUE	-493,624		42	3	0	0	
3520	16	RENT INCOME	-7,155		6	0	6	-7,155	
3530	13	BEAUTY SHOP	-883		0	0	0	0	
3560	12	ACTIVITY FUND INCOME	-980		0	0	0	0	
3570	12	VENDING INCOME/EXPENSE	0		0	0	0	0	
3525	12	CONTRIBUTIONS	-980		0	0	0	0	
3590	1	EQUIPMENT RENTAL	-15,068		0	0	0	0	
3595	21	RESIDENT TRANSPORTATION	-65		0	0	0	0	
3600	21	MISC INCOME	126		0	0	0	0	
4110		GENERAL & ADMINIST WAGES	387,752	428,377	21	1	17	0	
4111		ADMINISTRATOR WAGES	95,906	95,906	17	1	0	0	
4115		VACATION & SICK - G&A	40,625		21	1	0	0	
4120	4475	EMPLOYEE BENEFITS	83,253	718,622	22	3	0	0	
4125		EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130		EMPLOYEE SCHOLARSHIP WA	34,500	120,040	21	1	0	0	
4135		EMPLOYEE SCHOLARSHIP CC	13,330		23	3	0	0	
4220		DIRECTORS FEES	0	0	18	3	0	0	
4250	4255	OFFICE SUPPLIES	31,968	31,968	21	2	0	0	
4260		TELEPHONE	14,640	14,640	21	3	0	0	
4275		TRAINING & EMPLOYEE DEVL	1,233	1,233	23	3	16	0 **	
4280		GENERAL TRAVEL	365	880	24	3	16	0	
4281		MEAL EXPENSE FOR TRAVEL	0		24	3	19	0	
4285		EDUCATION & SEMINAR	515		24	3	19	-462 ***	
4290		HELP WANTED ADVERTISING	3,905	87,310	20	3	0	0	-48,312
4291		PROMOTIONAL ADVERTISING	10,597		20	3	25	-10,597	
4292		PUBLIC RELATIONS	6,663		20	3	25	-6,663	
4300		LICENSES & FEES	53,970		20	3	17	-1,448	
4310		DUES & SUBSCRIPTIONS	8,050		20	3	17	-3,870	
4320		CONTRIBUTIONS	0		27	3	20	0	
4350		PROFESSIONAL FEES	9,298	368,615	19	3	22	-5,897	
4355		MEDICAL DIRECTOR	35,331	35,331	9	3	0	0	
4360		UTILIZATION REVIEW	0		10	3	0	0	
4361		OTHER PHYSICIAN FEES			39	3	0	0	
4362		MEDICAL RECORDS CONSULT	865		10	3	0	0	
4363		PHARMACIST FEES	3,752		10	3	0	0	
4364		SOC SERV/ACT CONSULT	381	381	12	3	0	0	
4370		TV RENTAL	14,835		35	3	5	0	
4380		INCOME TAXES		-35,418	27	3	26	0	
4383		BACKGROUND CHECKS	4,125		20	3	26	0	
4400		PAYROLL TAXES	300,429		22	3	0	0	
4401		PAYROLL TAXES ADMINIST	0		22	3	0	0	
4410		GROUP INSURANCE	247,379		22	3	0	0	
4420		LIABILITY INSURANCE	52,600	52,600	26	3	0	0	
4425		INSURANCE-OWNERS			22	3	21	0	
4430		WORKMENS COMP INSURANC	39,731		22	3	0	0	
4450		CENTRAL OFFICE FEES	359,317		19	3	34	0 **	
4460		BAD DEBTS	-35,786		27	3	24	35,786	
4470		LOST ITEMS-RESIDENTS	368		27	3	0		
4490		MISCELLANEOUS	0		27	3	0	0	
4510		REAL ESTATE TAXES	0	0	33	3	0	0	
4600		LEASED EQUIPMENT	30,686	45,521	35	3	16	0	
5110		MAINTENANCE SALARIES	101,463	110,485	6	1	0	0	
5120		MAINTENANCE SICK & VAC	9,022		6	1	0	0	
5130		ELECTRIC	47,552	107,683	5	3	0	0	
5131		NATURAL GAS	23,568		5	3	0	0	
5132		HEATING & DEISEL OIL			5	3	0	0	
5133		WATER & SEWER	36,563		5	3	0	0	
5134		TRASH COLLECTION	12,533	123,619	6	3	0	0	
5140		PROPERTY PLANT REPLACEM	7,186	79,059	6	2	0	0	
5160		GENERAL REPAIR & MAINT	71,873		6	2	0	0	
5165		MAINTENANCE CONTRACTS	111,086		6	3	0	0	
5210		DIETARY WAGES	268,442	285,305	1	1	0	0	
5220		DIETARY SICK & VAC	16,863		1	1	0	0	
5240		DIETARY CONSULTANT	5,760	5,760	2	3	13	0	
5248		FOOD PURCHASES	248,279	247,953	2	2	0	0	
5250		SUPPLIES-DISHWASHING	5,355	30,306	1	2	0	0	
5260		DIETARY REPLACEMENT	6,226		1	2	0	0	
5270		KITCHEN SUPPLIES-PAPER	18,725		1	2	0	0	
5295		MEAL CREDIT	-326		2	2	0	0	
5310		LAUNDRY WAGES	72,955	81,139	4	1	0	0	
5340		LAUNDRY SICK & VAC	8,184		4	1	0	0	
5370		LAUNDRY REPLACEMENT	10,229	15,946	4	2	0	0	
5380		LAUNDRY REIMBURSEMENT			4	3	0	0	
5390		LAUNDRY SUPPLIES	5,717		4	2	0	0	
5410		HOUSEKEEPING WAGES	77,386	89,253	3	1	0	0	
5440		HOUSEKEEPING SICK & VAC	11,867		3	1	0	0	
5480		HOUSEKEEPING SUPPLIES	37,829	37,829	3	2	0	0	
5490		HOUSEKEEPING SUPPLIES-PF	0		3	2	0	0	
6010		RN WAGES-MEDICARE		2,530,801	10	1	0	0	
6020		RN WAGES-NON MEDICARE	718,865		10	1	0	0	
6030		DON WAGES	88,336		10	1	0	0	
6035		ADON	67,368		10	1	0	0	
6040		RN SICK & VACATION	53,267		10	1	0	0	
6110		LPN WAGES-MEDICARE	381,411		10	1	0	0	
6120		LPN WAGES-NON MEDICARE	0		10	1	0	0	
6130		LPN WAGES OTHER			10	1	0	0	
6140		LPN SICK & VACATION	30,502		10	1	0	0	
6210		AIDE WAGES-MEDICARE			10	1	0	0	
6220		AIDE WAGES-NON MEDICARE	1,104,753		10	1	0	0	
6230		WARD CLERKS			10	1	0	0	
6240		AIDE VACATION & SICK	48,385		10	1	0	0	
6245		CONTRACT NURSES-RN	17,996		10	3	0	0	
6246		CONTRACT NURSES-LPN	0		10	3	0	0	
6247		CONTRACT NURSES-AIDES	0		10	3	0	0	
6250		NURSE AIDE TRAINING WAGES	4,306	4,306	13	1	0	0	
6255		NURSE AID TRAINING EXP	4,282	4,282	13	2	0	0	
6260		NURSE AIDE TRAINING REIMB	0		0	0	0	0	
6270		REHAB WAGES	33,445		10	1	0	0	
6275		REHAB SICK & VAC	4,469		10	1	0	0	
6280		NURSING DEPT EDUCATION			23	3	0	0	
6290		NURSING SUPPLIES	11,699	218,578	10	2	0	0	
6295		NURSING SUPPLIES	202,393		10	2	0	0	
6390		REPLACEMENT-NURSING	4,486		10	2	0	0	
6490		NURSING OTHER	581	23,194	10	3	0	0	
7280		DRUG PURCHASES	317,512	317,512	39	2	0	0 ***	
7281		DRUG PURCHASES-OTHER	0		39	2			
7380		LABORATORY SERVICES	55,756	55,756	39	3	0	0	
7410		HOME HEALTH SALARY			39	1	0	0	
7440		HOME HEALTH SICK & VAC			39	1	0	0	
7450		HOME HEALTH EXPENSES			39	3	0	0	
7510		ACTIVITES WAGES	71,781	76,594	11	1	0	0	
7540		ACTIVITIES SICK & VAC	4,813		11	1	0	0	
7590		ACTIVITIES SUPPLIES	1,525	1,525	11	2	0	0	
7595		ACTIVITIES FEES	0	0	11	3	0	0	
7610		PT WAGES			39	1	0	0	
7611		PT SICK & VACATION			39	1	0	0	
7620		PT FEES	226,512	421,402	39	3	0	0 ***	
7660		PT SUPPLIES	0		39	2	0	0	
7710		SOCIAL SERVICE WAGES	53,951	58,252	12	1	0	0	
7720		SOCIAL SERVICE SICK & VAC	4,301		12	1	0	0	
7730		SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	
7740		OT FEE	156,448		39	3	0	0 ***	
7750		SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770		SPEECH THERAPY FEE	38,442		39	3	0	0 ***	
7800		BEAUTICIAN WAGES		0	40	1	0	0	
7810		BEAUTICIAN SICK & VAC			40	1	0	0	
7820		BEAUTICIAN FEES	0	0	40	3	0	0	
7890		BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910		VOLUNTEER COORDINATOR			21	1	0	0	
7940		VOL COORD SICK & VAC			21	1	0	0	
7960		VOL COORD SUPPLIES	0		21	2	0	0	
8100		RENT	486,180	486,180	34	3	0	0	
8120		INTEREST EXPENSE	42,755	42,755	32	3	14	-109	
8130		DEPRECIATION	0	0	30	3	9	0	
8150		LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510		INTEREST INCOME	-109		32	0	10	0	
9520		MISC NON-OPERATING INCOM	0		0	0	0	0	
9700		INCOME TAXES	0		0	0	0	0	
			7,301,331	7,421,480					
				120,149					
GRAND TOTALS			142,595					-415	
			(NET INCOME)						
			0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 162

BALANCE SHEET TOTAL 0

1,009	1,009 CASH	400
1,100	1,100 ACCTS RI	147,646
1,101	1,101 ALLOW. F	(64,850)
1,110	1,110 ACCTS RECEIV-MC	
1,125	1,125 ACCTS RECEIV-IPA	
1,132	1,132 US HHS S	(203,730)
1,140	1,140 UNAPPLIED CASH RECEIPTS	
1,145	1,145 A/R SUSPENSE-REFUNDS	
1,200	1,200 PREPAID	1,807
1,220	1,220 OTHER PI	0
1,300	1,300 DIETARY I	12,753
1,310	1,310 SUPPLIES INVENTORY	
1,320	1,320 LINEN INVENTORY	
1,409	1,409 LAND	0
1,450	1,450 FURNITUF	0
1,460		0
1,475	1,475 BUILDING:	0
1,490	1,490 ACCUM DI	0
1,530	1,530 RESIDENT	14,564
1,550	1,550 LOAN FEE	0
1,551	1,551 LOAN FEES ADDED	
1,850	1,850 INTERCOI	(1,391,182)
2,010	2,010 ACCOUNT	0
2,100	2,095 BONUSES PAYABLE	
2,100	2,100 ACCRUEL	(54,951)
2,100	2,100 PR CLEARING-BENEFITS	
2,100	2,100 PR CLEARING-LABOR	
2,110	2,110 ACCRUEL	(205,629)
2,120	2,120 U.C. TAXE	0
2,125	2,125 FICA TAXE	(12,888)
2,130	2,130 FEDERAL W/H TAX PAYABLE	
2,140	2,140 STATE W/H TAX PAYABLE	
2,152	2,152 WORKERS COMP ACCRUAL	
2,225	2,225 EMPLOYEEE INSURANCE REFUND	
2,230	2,230 PAYROLL SAVINGS	
2,235	2,240 UNITED FUND	
2,240	2,246 GROUP INSURANCE - CAFETERIA	
2,246	2,250 401K W/H	
2,250		
2,260	2,260 WAGE GA	0
2,300	2,300 ACCRUEL	0
2,320	2,320 IPA PAYMI	(8,941)
2,350	2,350 REAL EST	0
2,385		0
2,400	2,400 CURRENT PORTION OF LT DEBT	
2,512	2,512 DUE TO R	(14,564)
2,600	2,600 LOC	0
2,600		0
2,625	2,625 LASALLE CONSTR. LOAN #2	
2,625		
2,695	2,695 CURRENT PORTION OF LT DEBT	
2,720	2,720 RETAINEL	1,635,991
	net income	143,575
	balance	0

3,007	3,007 PATIENT I	13,144
3,007	3,007 PATIENT I	5,894
3,007	3,007 PATIENT I	2,846
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CH	(6,644,862)
3,020	3,020 BASIC CH	0
3,030	3,030 BASIC CH	0
3,040	ASSESSM	120,040
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING	(12,494)
3,081	3,081 NURSING	0
3,082	3,082 NURSING	0
3,083	3,083 NURSING	0
3,100	3,100 DRUGS-M	(598,552)
3,101		0
3,110	3,110 PHYSICAL	(1,648,467)
3,111		0
3,112	3,112 PHYSICAL	0
3,113	3,113 PHYSICAL	0
3,140	3,140 LABORATORY INCOME	
3,150		0
3,151		
3,152	3,152 ST/OT TH	0
3,153	3,153 ST/OT TH	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTHE	0
3,411	3,411 MEDICARI	0
3,420	3,420 MEDICARI	2,143,698
3,452	3,452 HHS STIM	(493,624)
3,520	3,520 RENT INC	(7,155)
3,530	3,530 BEAUTY S	(883)
3,525	3,525 CONTRIBI	(980)
3,570	3,570 VENDING	0
3,590	3,590 EQUIPMEI	(15,068)
3,595	3,595 RESIDENT	(65)
3,600	3,600 MISC INC(	126
4,110	4,110 G&A WAG	387,752
4,111	4,111 ADMINISTI	95,906
4,115	4,115 G&A PTO	40,625
4,120	4,120 EMPLOYE	82,536
4,121		0
4,130	4,130 EMPLOYE	34,500
4,135	4,135 EMPLOYE	13,330
4,250	4,250 OFFICE S	8,965
4,255	4,255 POSTAGE	2,784
4,260	4,260 TELEPHO	14,640
4,275	4,275 TRAINING	1,233
4,276		0
4,280	4,280 GENERAL	365
4,281	4,281 MEAL EXF	0
4,285	4,285 EDUCATI(	515
4,289	4,289 MEETING:	0
4,290	4,290 HELP WAI	3,905
4,291	4,291 PROMOTI	10,597
4,292	4,292 PUBLIC R	6,663
4,300	4,300 LICENSE ;	53,970
4,310	4,310 DUES & S	8,050
4,320	4,320 CONTRIBI	0
4,350	4,350 PROFESS	9,298
4,355	4,355 MEDICAL	35,331
4,362		865
4,363		3,752
4,364	4,364 SOCIAL S	381
4,370	4,370 TV RENTA	14,835
4,383	4,383 BACKGR(	4,125
4,390	4,390 OTHER T/	0
4,400	4,400 PAYROLL	300,429
4,401	4,401 PAYROLL	0
4,410	4,410 GROUP IN	247,379
4,420	4,420 LIABILITY	52,600
4,430	4,430 WORKMA	38,059
4,435	4,435 W/C-FIRS	0
4,436	4,436 DRUG TE:	1,672
4,450	4,450 MANAGEM	359,317
4,460	4,460 BAD DEBT	(35,786)
4,461	4,461 BAD DEBT	530
4,470	4,470 LOST ITEI	368
4,475	4,475 UNIFORM	717
4,486	4,486 SERVICE	64,443
4,490	4,490 MISC EXP	1,470
4,496	4,496 MISC. M.I.:	20,219
4,510	4,510 REAL EST	0
4,600	4,600 LEASED E	30,686
5,110	5,110 MAINTENA	101,463
5,120	5,120 MAINTENA	9,022
5,130	5,130 ELECTRIC	47,552
5,131	5,131 NATURAL	23,568
5,133	5,133 WATER &	36,563
5,134	5,134 TRASH C(	12,533
5,140	5,140 PROP/PL/	7,186
5,160	5,160 GENERAL	71,873
5,165	5,165 MAINTENA	46,643
5,210	5,210 DIETARY	268,442
5,220	5,220 DIETARY	16,863
5,248	5,248 FOOD PU	246,809
5,250	5,250 SUPPLIES	5,355
5,260	5,260 REPLACE	6,226
5,270	5,270 KITCHEN	18,725
5,295	5,295 MEAL INC	(326)
5,310	5,310 LAUNDRY	72,955
5,340	5,340 LAUNDRY	8,184
5,370	5,370 REPLACE	10,229
5,230	5,230 DIETARY	5,760
5,390	5,390 LAUNDRY	5,717
5,410	5,410 HOUSEKE	77,386
5,440	5,440 HOUSEKE	11,867
5,480	5,480 SUPPLIES	37,829
5,490	5,490 SUPPLIES	0
6,020	6,020 RN WAGE	718,865
6,030	6,030 DON WAG	88,336
6,035	6,035 ADON WA	67,368
6,040	6,040 RN PTO &	53,267
6,120	6,120 LPN WAG	381,411
6,140	6,140 LPN PTO	30,502
6,220	6,220 AIDES WA	1,104,753
6,240	6,240 AIDES PT	48,385
6,245	RN CONT	17,996
6,246	LPN CON	0
6,247	AIDES CO	0
6,250		4,306
6,255		4,282
6,260		0
6,270	6,270 REHAB W	33,445
6,275	6,275 REHAB PT	4,469
6,290	6,290 NURSING	11,699
6,295	6,295 NURSING	202,393
6,390	6,390 REPLACE	4,486
6,490	6,490 OTHER	581
7,280	7,280 DRUG PU	317,512
7,281	7,281 DRUG PU	0
7,380	7,380 LABORAT	20,662
7,391	7,390 X-RAY SE	20,418
7,393		14,676
7,510	7,510 ACTIVITIE	71,781
7,540	7,540 ACTIVITIE	4,813
7,590	7,590 ACTIVITIE	1,525
7,620	7,620 PHYSICAL	226,512
7,660	7,660 P.T. SUPF	0
7,710	7,710 SOCIAL S	53,951
7,720	7,720 SOCIAL S	4,301
7,730	7,730 SOCIAL S	0
7,740	7,740 OCCUPAT	156,448
7,750		
7,770	7,770 SPEECH	38,442
7,820	7,820 BEAUTICI	0
7,890		0
7,960		0
8,120	8,120 INTEREST	0
8,125		42,755
8,130	8,130 DEPRECI	0
8,150		0
9,510	9,510 INTEREST	(109)
9,520	9,520 MISC NON	0
9,530	4,220	0
	8,100	486,180
	9,702	0
	5,230	0
		143,575

Expenses Fixed Assets
0

Heritage Manor - Bloomington
IDPH ID# 48157
HFS Cost Report - December 31, 2020
Schedule V - Column 5 Reclassifications

1. Schedule V - Line 10a to Line 39 - Reclassifications

Line Item		
Purchased Drugs and Medications	$	317,512
Purchased Hospital Services		23,380
Purchased Laboratory Services		20,662
Purchased Radiology Services		11,714
Amount Reclassified to Line 39	$	373,268

2. Schedule V - Line 20 to Line 42 - Reclassification

Line Item		
Provider Participation Fee - $1.50	$	(48,312)
Provider Assesment Fee - $6.07		(120,040)
	$	(168,352)
Provider Participation Fee	$	168,352

3. Schedule V - Line 10 to Line 10a - Reclass Pharmacy Consultant cost

Line Item		
Pharmacy Consultant	$	3,752