		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: 0048868

Facility Name: Heritage Health Chillicothe

Address: 1028 Hillcrest Drive (Number) Chillicothe (City) 61523 (Zip Code)

County: Peoria

Telephone Number: (309) 274-2194 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: July 2007

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 Chillicothe # 0048868 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	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	106	Skilled (SNF)	106	38,796	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	106	TOTALS	106	38,796	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	19,240	6,306	2,198	27,744	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,240	6,306	2,198	27,744	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.51%

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 July 2007

J. Was the facility purchased or leased after January 1, 1978?
YES [xx] Date 1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 106 and days of care provided 2,198

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 Chillicothe # 0048868 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 Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	302,109	19,337	7,512	328,958		328,958	5,172	334,130			1
2	Food Purchase		223,457		223,457		223,457	(18)	223,439			2
3	Housekeeping	112,083	34,775		146,858		146,858	6,895	153,753			3
4	Laundry	47,009	12,339		59,348		59,348	493	59,841			4
5	Heat and Other Utilities			74,501	74,501		74,501	1,641	76,142			5
6	Maintenance	58,449	58,170	129,557	246,176		246,176	20,121	266,297			6
7	Other (specify):*											7
8	TOTAL General Services	519,650	348,078	211,570	1,079,298		1,079,298	34,304	1,113,602			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,523,051	174,931	108,303	2,806,285	(6,657)	2,799,628	2,173	2,801,801			10
10a	Therapy		277,359	37,645	315,004	(308,243)	6,761		6,761			10a
11	Activities	142,879	2,814		145,693		145,693	5	145,698			11
12	Social Services	52,289		1,795	54,084		54,084	148	54,232			12
13	CNA Training	2,007	(904)		1,103		1,103		1,103			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,720,226	454,200	159,743	3,334,169	(314,900)	3,019,269	2,326	3,021,595			16
	C. General Administration											
17	Administrative	103,055			103,055		103,055		103,055			17
18	Directors Fees											18
19	Professional Services			371,969	371,969		371,969	(349,830)	22,139			19
20	Dues, Fees, Subscriptions & Promotions			276,836	276,836	(224,639)	52,197	(30,055)	22,142			20
21	Clerical & General Office Expenses	259,700	22,456	11,294	293,450		293,450	441,238	734,688			21
22	Employee Benefits & Payroll Taxes			616,199	616,199		616,199	44,435	660,634			22
23	Inservice Training & Education			652	652		652	1,325	1,977			23
24	Travel and Seminar			2,283	2,283		2,283	2,716	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,815	62,815		62,815	73,611	136,426			26
27	Other (specify):* Lost resident items			20,361	20,361		20,361	(19,230)	1,131			27
28	TOTAL General Administration	362,755	22,456	1,362,409	1,747,620	(224,639)	1,522,981	164,210	1,687,191			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,602,631	824,734	1,733,722	6,161,087	(539,539)	5,621,548	200,840	5,822,388			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 Chillicothe #0048868 **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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							414,157	414,157			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,444	53,444		53,444	165,047	218,491			32
33	Real Estate Taxes							97,997	97,997			33
34	Rent-Facility & Grounds			482,770	482,770		482,770	(474,142)	8,628			34
35	Rent-Equipment & Vehicles			60,958	60,958		60,958	13,557	74,515			35
36	Other (specify):*											36
37	**TOTAL Ownership**			597,172	597,172		597,172	216,616	813,788			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			601,374	601,374	314,900	916,274	219,326	1,135,600			39
40	Barber and Beauty Shops			1,623	1,623		1,623		1,623			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					224,639	224,639		224,639			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			602,997	602,997	539,539	1,142,536	219,326	1,361,862			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,602,631	824,734	2,933,891	7,361,256		7,361,256	636,782	7,998,038			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 Chillicothe # 0048868 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				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	(3,045)			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	(6,228)			17
18	Fines and Penalties				18
19	Entertainment	(2,802)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,627)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,230)			24
25	Fund Raising, Advertising and Promotional	(24,845)			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)**	$ (57,777)		$	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)	694,559		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 694,559		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 636,782		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 Chillicothe

ID# 0048868

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		(1,627)	19	11
12		(3,045)	32	12
13		(19,230)	27	13
14		(24,845)	20	14
15		(6,228)	20	15
16		0	27	16
17		(2,802)	24	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	(57,777)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	5,172	0	0	0	0	0	0	0	0	5,172	1
2	Food Purchase	0	0	(18)	0	0	0	0	0	0	0	0	(18)	2
3	Housekeeping	0	0	6,895	0	0	0	0	0	0	0	0	6,895	3
4	Laundry	0	0	493	0	0	0	0	0	0	0	0	493	4
5	Heat and Other Utilities	0	0	1,641	0	0	0	0	0	0	0	0	1,641	5
6	Maintenance	0	0	20,121	0	0	0	0	0	0	0	0	20,121	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	34,304	0	0	0	0	0	0	0	0	34,304	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	(24,609)	26,782	0	0	0	0	0	0	0	0	2,173	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	148	0	0	0	0	0	0	0	0	148	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	(24,609)	26,935	0	0	0	0	0	0	0	0	2,326	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	(1,627)	(365,758)	17,555	0	0	0	0	0	0	0	0	(349,830)	19
20	Fees, Subscriptions & Promotions	(31,073)	0	1,018	0	0	0	0	0	0	0	0	(30,055)	20
21	Clerical & General Office Expenses	0	0	441,238	0	0	0	0	0	0	0	0	441,238	21
22	Employee Benefits & Payroll Taxes	0	0	44,435	0	0	0	0	0	0	0	0	44,435	22
23	Inservice Training & Education	0	(72)	1,397	0	0	0	0	0	0	0	0	1,325	23
24	Travel and Seminar	(2,802)	0	5,518	0	0	0	0	0	0	0	0	2,716	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	73,611	0	0	0	0	0	0	0	0	73,611	26
27	Other (specify):*	(19,230)	0	0	0	0	0	0	0	0	0	0	(19,230)	27
28	TOTAL General Administration	(54,732)	(365,830)	584,772	0	0	0	0	0	0	0	0	164,210	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,732)	(390,439)	646,011	0	0	0	0	0	0	0	0	200,840	29

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	389,284	0	24,873	0	0	0	0	0	0	0	414,157	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,045)	165,300	0	2,792	0	0	0	0	0	0	0	165,047	32
33	Real Estate Taxes	0	97,997	0	0	0	0	0	0	0	0	0	97,997	33
34	Rent-Facility & Grounds	0	(481,800)	0	7,658	0	0	0	0	0	0	0	(474,142)	34
35	Rent-Equipment & Vehicles	0	0	0	13,557	0	0	0	0	0	0	0	13,557	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,045)	170,781	0	48,880	0	0	0	0	0	0	0	216,616	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	219,127	0	199	0	0	0	0	0	0	0	219,326	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	219,127	0	199	0	0	0	0	0	0	0	219,326	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(57,777)	(531)	646,011	49,079	0	0	0	0	0	0	0	636,782	45

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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
Monroe 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		$ (24,609)	$ (24,609)	1
2	V	23	Adjustment for Related Organization		GreenTree Pharmacy		(72)	(72)	2
3	V	39	Adjustment for Related Organization		GreenTree Pharmacy		219,127	219,127	3
4	V	19	Adjustment for Related Organization	365,758	Heritage Operations Group, LLC			(365,758)	4
5	V								5
6	V	34	Adjustment for Related Organization	481,800	Heritage Manor Real Estate, LLC			(481,800)	6
7	V	33	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		97,997	97,997	7
8	V	32	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		165,300	165,300	8
9	V	30	Adjustment for Related Organization		Heritage Manor Real Estate, LLC		389,284	389,284	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 847,558			$ 847,027	$ * (531)	14

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

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	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)	
15	V	1	Dietary	$	Heritage Operations Group		$ 5,172	$ 5,172	15
16	V	2	Food Purchase		Heritage Operations Group		(18)	(18)	16
17	V	3	Housekeeping		Heritage Operations Group		6,895	6,895	17
18	V	4	Laundry		Heritage Operations Group		493	493	18
19	V	5	Heat & Other Utilities		Heritage Operations Group		1,641	1,641	19
20	V	6	Maintenance		Heritage Operations Group		20,121	20,121	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		26,782	26,782	23
24	V	11	Activities		Heritage Operations Group		5	5	24
25	V	12	Social Service		Heritage Operations Group		148	148	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		17,555	17,555	31
32	V	20	Fees, Subscription, Promotions		Heritage Operations Group		1,018	1,018	32
33	V	21	Clerical & General Office Expenses		Heritage Operations Group		441,238	441,238	33
34	V	22	Employee Benefits & Payroll Taxes		Heritage Operations Group		44,435	44,435	34
35	V	23	Inservice Training & Education		Heritage Operations Group		1,397	1,397	35
36	V	24	Travel and Seminar		Heritage Operations Group		5,518	5,518	36
37	V	25	Other Admin. Staff Transportation		Heritage Operations Group		0		37
38	V	26	Insurance-Prop.Liab.Malpract		Heritage Operations Group		73,611	73,611	38
39	Total			$			$ 646,011	$ * 646,011	39

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

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	Other	$	Heritage Operations Group		$ 0	$	15
16	V	30	Depreciation		Heritage Operations Group		24,873	24,873	16
17	V	31	Amortization of Pre-Op & Org		Heritage Operations Group		0		17
18	V	32	Interest		Heritage Operations Group		2,792	2,792	18
19	V	33	Real Estate Taxes		Heritage Operations Group		0		19
20	V	34	Rent-Facility & Grounds		Heritage Operations Group		7,658	7,658	20
21	V	35	Rent-Equipment & Vehicles		Heritage Operations Group		13,557	13,557	21
22	V	36	Other		Heritage Operations Group		0		22
23	V	38	Medically Nec Transportation		Heritage Operations Group		0		23
24	V	39	Ancillary Service Centers		Heritage Operations Group		199	199	24
25	V	40	Barber and Beauty Shops		Heritage Operations Group		0		25
26	V	41	Coffee and Gift Shops		Heritage Operations Group		0		26
27	V	42	Other		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			$			$ 49,079	$ * 49,079	39

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

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Monroe 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 Chillicothe # 0048868 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

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

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

	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	106	$ 5,172	1
2	2	Food Purchase	Beds	2,493	25	(423)	0	106	(18)	2
3	3	Housekeeping	Beds	2,493	25	162,156	0	106	6,895	3
4	4	Laundry	Beds	2,493	25	11,591	0	106	493	4
5	5	Heat & Other Utilities	Beds	2,493	25	38,605	0	106	1,641	5
6	6	Maintenance	Beds	2,493	25	473,233	88,567	106	20,121	6
7	7	Other	Beds	2,493	25	0	0	106	0	7
8	9	Medical Director	Beds	2,493	25	0	0	106	0	8
9	10	Nursing & Medical Records	Beds	2,493	25	629,872	35,401	106	26,782	9
10	11	Activities	Beds	2,493	25	129	0	106	5	10
11	12	Social Service	Beds	2,493	25	3,478	3,478	106	148	11
12	13	Nurse Aide Training	Beds	2,493	25	0	0	106	0	12
13	14	Program Transportation	Beds	2,493	25	0	0	106	0	13
14	15	Other	Beds	2,493	25	0	0	106	0	14
15	17	Administrative	Beds	2,493	25	0	0	106	0	15
16	18	Directors Fees	Beds	2,493	25	0	0	106	0	16
17	19	Professional Services	Beds	2,493	25	412,869	0	106	17,555	17
18	20	Fees, Subscription, Promotions	Beds	2,493	25	23,945	0	106	1,018	18
19	21	Clerical & General Office Expense	Beds	2,493	25	10,377,428	9,978,005	106	441,238	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,493	25	1,045,059	0	106	44,435	20
21	23	Inservice Training & Education	Beds	2,493	25	32,865	0	106	1,397	21
22	24	Travel and Seminar	Beds	2,493	25	129,776	0	106	5,518	22
23	25	Other Admin. Staff Transportatio	Beds	2,493	25	0	0	106	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,493	25	1,731,253	0	106	73,611	24
25	TOTALS					$ 15,193,470	$ 10,226,789		$ 646,011	25

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	$	$	106	$	1
2	30	Depreciation	Beds	2,493	25	584,981		106	24,873	2
3	31	Amortization of Pre-Op & Org	Beds	2,493	25			106		3
4	32	Interest	Beds	2,493	25	65,658		106	2,792	4
5	33	Real Estate Taxes	Beds	2,493	25			106		5
6	34	Rent-Facility & Grounds	Beds	2,493	25	180,106		106	7,658	6
7	35	Rent-Equipment & Vehicles	Beds	2,493	25	318,843		106	13,557	7
8	36	Other	Beds	2,493	25			106		8
9	38	Medically Nec Transportation	Beds	2,493	25			106		9
10	39	Ancillary Service Centers	Beds	2,493	25	4,685		106	199	10
11	40	Barber and Beauty Shops	Beds	2,493	25			106		11
12	41	Coffee and Gift Shops	Beds	2,493	25			106		12
13	42	Other	Beds	2,493	25			106		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	$		$ 49,079	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Busey Bank		xx	Mortgage			$	$			$ 165,300	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Busey Bank		xx	Working Capital							53,444	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 218,744	9
	B. Non-Facility Related*											
10	Interest Income										(3,045)	10
11												11
12	Allocated Corporate										2,792	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (253)	14
15	TOTALS (line 9+line14)						$	$			$ 218,491	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 Chillicothe # 0048868 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2019 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.)	$ 97,997	2
3. Under or (over) accrual (line 2 minus line 1).	$ 97,997	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.	$ 97,997	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2015	82,848	8
	2016	94,249	9
	2017	94,944	10
	2018	94,883	11
	2019	97,997	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 Chillicothe COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0048868

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.	0529376017		$ 1,376.42	$ 1,376.00
2.	0529376016		$ 96,620.42	$ 96,621.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 97,996.84	$ 97,997.00

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 Chillicothe # 0048868 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,914 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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).
Evergreen Place Chillicothe LLC - Assisted living (53 units) and Memory Care (20 units). Property is adjacent only-no sharing.

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			Jun-98	$ 129,000	1
2					2
3	TOTALS			$ 129,000	3

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	106				$ 3,301,403	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1998 Improvements			1998	58,638						9
10	1999 Improvements			1999	178,823						10
11	2000 Improvements			2000	214,554						11
12	2001 Improvements			2001	38,910						12
13	2002 Improvements			2002	12,493						13
14	2003 Improvements			2003	20,779						14
15	2004 Improvements			2004	32,228						15
16	2005 Improvements			2005	229,475						16
17	2006 Improvements			2006	96,493						17
18	2007 Improvements			2007	66,221						18
19	2008 Improvements			2008	84,318						19
20	2009 Improvements			2009	323,250						20
21	2010 Improvements			2010	143,405						21
22	2011 Improvements			2011	175,259						22
23	2012 Improvements			2012	21,194						23
24	2013 Improvements			2013	80,466						24
25	2014 Improvements			2014	9,009						25
26											26
27	Replaced kitchen garbage disposal			2015	2,914						27
28	Boiler- Replaced pressure regulator and relief valve			2015	5,392						28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation					24,873		24,873			34
35	Book Depreciation					344,111		344,111			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 Chillicothe # 0048868 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			$	$		$	$	$	37
38	Install flood lights for the back parking lot	2016	2,926						38
39	Landscaping front parking lot and front entrance -	2016	10,585						39
40	removing previous materials and replacing with new								40
41	mulch, topsoil, bricks and plants								41
42									42
43	Full Facility Renovation Project -	2016	2,653,564						43
44	Each of the 54 Patient Rooms received New Flooring, Cabinetry, Furniture								44
45	(including beds), wallcover removal and fresh painting								45
46	New Flooring in all hallways and other common areas;								46
47	New Tables and Chairs in both dining areas; New Cabinets								47
48	and Flooring for both Nursing Stations; New Plumbing								48
49	fixtures throughout entire facility;								49
50	Constructed a new dining area - 852 square foot contiguous								50
51	addition to existing building;								51
52	Relocated existing therapy unit to old dining room-installed new flooring and equipment								52
53									53
54	Installed split heating/cooling system - laundry room	2017	6,430						54
55									55
56	Replace fire alarm panel	2018	46,163						56
57	Install new water softener	2018	5,630						57
58	Installed split heating/cooling system	2018	3,750						58
59	Replace fluid controls	2018	12,845						59
60									60
61	Install new heat pump	2019	5,295						61
62	Replace condenser and fan motor - Walk-in freezer	2019	3,783						62
63	Install new water system	2019	13,789						63
64	Replace exterior door - boiler room	2019	3,785						64
65									65
66	Replace hot water boiler	2020	10,800						66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,874,569	$ 368,984		$ 368,984	$	$	70

**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	$ 1,076,912	$ 45,173	$ 45,173	$		$	71
72	Current Year Purchases	14,911						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,091,823	$ 45,173	$ 45,173	$		$	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		2006 Turtletop Van	2006	$ 57,088	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 57,088	$	$	$		$	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)	$ 9,152,480	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 414,157	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 414,157	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.

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 [ ] 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 [ ] NO

16. Rental Amount for movable equipment: $ 60,958 Description: Televisions, office equipment & oxygen concentrators
(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 Chillicothe # 0048868 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		(904)		(904)
3	Classroom Wages (a)				
4	Clinical Wages (b)		2,007		2,007
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 1,103	$	$ 1,103
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,103			

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	$		$ 258,267	$		$ 258,267	1
2	Licensed Speech and Language Development Therapist			hrs			27,133			27,133	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist			hrs			315,974	104		316,078	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				277,255		277,255	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify):						37,645			37,645	13
14	TOTAL				$		$ 639,019	$ 277,359		$ 916,378	14

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

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	$ 1,319	$	1
2	Cash-Patient Deposits	15,509		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	132,533		3
4	Supply Inventory (priced at FIFO)	1,869		4
5	Short-Term Investments			5
6	Prepaid Insurance	1,691		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	25,588		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 178,509	$	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)**	$ 178,509	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,509		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	267,012		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,697		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	13,396		36
37	Deferred Stimulus	244,188		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 543,802	$	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)**	$ 543,802	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (365,293)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 178,509	$	48

*(See instructions.)

Facility Name & ID Number Heritage Health Chillicothe # 0048868 **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**	$ (507,956)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (507,956)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	142,663	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)**	$ 142,663	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)**	$ (365,293)	24 *

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

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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	$ 6,572,597	1
2	Discounts and Allowances for all Levels	(1,870,773)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,701,824	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,888,255	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,888,255	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	427,964	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,713	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	467,897	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,191	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 910,765	23
	D. Non-Operating Revenue		
24	Contributions	30	24
25	Interest and Other Investment Income***	3,045	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,075	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)**	$ 7,503,919	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,079,298	31
32	Health Care	3,334,169	32
33	General Administration	1,747,620	33
	B. Capital Expense		
34	Ownership	597,172	34
	C. Ancillary Expense		
35	Special Cost Centers	602,997	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)***	$ 7,361,256	40
41	**Income before Income Taxes (line 30 minus line 40)****	142,663	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 142,663	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 Chillicothe # 0048868 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	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,034	2,119	$ 91,954	$ 43.39	1
2	Assistant Director of Nursing	657	684	21,199	30.99	2
3	Registered Nurses	14,535	15,141	541,592	35.77	3
4	Licensed Practical Nurses	19,643	20,462	640,045	31.28	4
5	CNAs & Orderlies	70,283	73,212	1,163,071	15.89	5
6	CNA Trainees	207	216	2,007	9.29	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,861	1,938	65,190	33.64	8
9	Activity Director					9
10	Activity Assistants	9,185	9,567	142,879	14.93	10
11	Social Service Workers	2,067	2,153	52,289	24.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,751	22,657	302,109	13.33	15
16	Dishwashers					16
17	Maintenance Workers	1,899	1,978	58,449	29.55	17
18	Housekeepers	8,537	8,892	112,083	12.60	18
19	Laundry	3,690	3,844	47,009	12.23	19
20	Administrator	1,965	2,047	103,055	50.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,189	10,614	259,700	24.47	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)	168,503	175,524	$ 3,602,631 *	$ 20.53	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 7,512	L1 C3	35
36	Medical Director		12,000	L9 C3	36
37	Medical Records Consultant		736	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		6,657	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		1,795	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 28,700		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$ 29,856	L10 C3	50
51	Licensed Practical Nurses		8,797	L10 C3	51
52	Certified Nurse Assistants/Aides		62,201	L10 C3	52
53	TOTAL (lines 50 - 52)		$ 100,854		53

Facility Name & ID Number: Heritage Health Chillicothe # 0048868 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Stachowiak	Administrator		$ 103,055
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 103,055

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	$ 370,342
Legal adj to Zero		1,627
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 371,969

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,986
Unemployment Compensation Insurance	12,221
FICA Taxes	275,601
Employee Health Insurance	135,786
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	130,605
Central Office Allocation	44,435
TOTAL (agree to Schedule V, line 22, col.8)	$ 660,634

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,288
Health Care Worker Background Check (Indicate # of checks performed)	2,785
Patient Background Checks	
PR	2,765
Dues & Subscriptions	9,016
License & Fees	1,263
Central Office Allocation	1,018
Less: Public Relations Expense	(2,765)
Non-allowable advertising	(6,228)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,142

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,283
	0
Seminar Expense	0
	2,716
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,999

**See instructions.

Facility Name & ID Number Heritage Health Chillicothe # 0048868 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 - $7,422**

(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. $ **224,639**
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. $ **405**

(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	1,319						
1010	CASH IN BANK							
1040	CASH IN BANK-PAYROLL							
1100	ACCOUNTS RECEIVABLE	132,533						
1110	MEDICARE RECEIVABLES							
1125	IPA INCOME RECEIVABLE							
1130	MEDICARE COST REPORT							
1132	US HHS STIMULUS SETTLEME	-244,188						
1140	UNAPPLIED CASH RECEIPTS							
1145	A/R SUSPENSE-REFUNDS							
1190	ACCRUED INTEREST REC							
1200	PREPAID INSURANCE	1,691						
1220	OTHER PREPAID EXPENSES							
1300	FOOD INVENTORY	1,869						
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	15,509						
1550	LOAN FEES	0						
1560	REAL ESTATE TAX ESCROW							
1575	REIMBURSABLE PURCHASES							
1850	INTRACOMPANY	25,588						
2010	ACCOUNTS PAYABLE	0						
2095	BONUSES PAYABLE							
2100	ACCRUED PAYROLL	-110,435						
2110	ACCRUED VACATION PAY	-156,577						
2120	UC TAXES PAYABLE							
2125	FICA TAX PAYABLE	-3,697	-3,697					
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 PAYABL	0						
2310	SALES TAX PAYABLE							
2320	IPA PAYMENTS PAYABLE	-13,396						
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	-15,509						
2600	MORTGAGE PAYABLE	0						
2650	EQUIPMENT LOAN PAYABLE							
2695	CURRENT PORTION LT DEBT							
2696	DEFERRED INCOME TAXES							
2710	COMMON STOCK							
2720	RETAINED EARNINGS	507,956						
2970	PROFIT/LOSS FOR PERIOD	-142,663						
3007.1	PATIENT DAYS-PRIVATE	6,306						
3007.2	PATIENT DAYS-IPA	19,240						
3007.3	PATIENT DAYS-MEDICARE	2,198						
3007.4	PATIENT DAYS-CONVERSION							
3007.5	PATIENT DAYS-LICENSED							
3007.6	PATIENT DAYS-TOTAL							
3010	1 BASIC CHARGE-PRIVATE & VA	-6,556,649		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	-13,200		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	-467,897		0	0	0	0	
3101	17 DRUGS-OTHER							
3110	6 PT-PRIVATE	-1,888,255		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	166,445						
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	1,870,773		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	-427,964		42	3	0	0	
3520	16 RENT INCOME	0		6	0	6	0	
3530	13 BEAUTY SHOP	-2,713		0	0	0	0	
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0	
3570	12 VENDING INCOME/EXPENSE	-90		0	0	0	0	
3580	12 CONTRIBUTIONS	-30		0	0	0	0	
3590	1 EQUIPMENT RENTAL	-2,748		0	0	0	0	
3595	21 RESIDENT TRANSPORTATION	-12,093		0	0	0	0	
3600	21 MISC INCOME	-11		0	0	0	0	
4110	GENERAL & ADMINIST WAGES	232,815	259,700	21	1	17	0	
4111	ADMINISTRATOR WAGES	103,055	103,055	17	1	0	0	
4115	VACATION & SICK - G&A	26,885		21	1	0	0	
4120 4475	EMPLOYEE BENEFITS	128,660	616,199	22	3	0	0	
4125	EMPLOYEE HEP/ETITIS VACCIN	0		22	3	0	0	
4130	EMPLOYEE SCHOLARSHIP W/	6,340	166,445	21	3	0	0	
4135	EMPLOYEE SCHOLARSHIP C/	-14,425		21	3	0	0	
4220	DIRECTORS FEES	0	0	19	3	0	0	
4250 4255	OFFICE SUPPLIES	22,456	22,456	21	2	0	0	
4260	TELEPHONE	11,294	11,294	21	3	0	0	
4275	TRAINING & EMPLOYEE DEVL	652	652	22	3	16	0	***
4280	GENERAL TRAVEL	2,263	2,263	24	3	16	0	
4281	MEAL EXPENSE FOR TRAVEL	0		24	3	16	0	
4285	EDUCATION & SEMINAR			24	3	19	-2,602	***
4290	HELP WANTED ADVERTISING	14,289	110,391	20	3	0	-58,194	
4291	PROMOTIONAL ADVERTISING	22,060		20	3	25	-22,060	
4292	PUBLIC RELATIONS	2,765		20	3	25	-2,765	
4300	LICENSES & FEES	59,457		20	3	17	501	
4310	DUES & SUBSCRIPTIONS	9,014		20	3	17	-5,207	
4320	CONTRIBUTIONS			27	3	20	0	
4330	PROFESSIONAL FEES	6,211	371,969	19	3	22	-1,827	
4350	MEDICAL DIRECTOR	12,000	12,000	9	3	0	0	
4360	UTILIZATION REVIEW	0		10	3	0	0	
4361	OTHER PHYSICIAN FEES			39	3	0	0	
4362	MEDICAL RECORDS CONSULT	736		10	3	0	0	
4363	PHARMACIST FEES	6,657		10	3	0	0	
4364	SOC SERVICE CONSULT	1,795	1,795	12	3	0	0	
4370	TV RENTAL	14,862		35	3	0	0	
4380	INCOME TAXES		26,361	27	3	26	0	
4385	BACKGROUND CHECKS	2,765		20	3	26	0	
4400	PAYROLL TAXES	287,822		22	3	0	0	
4401	PAYROLL TAXES ADMINIST	0		22	3	0	0	
4410	GROUP INSURANCE	126,786		22	3	0	0	
4420	LIABILITY INSURANCE	62,815	62,815	26	3	0	0	
4425	INSURANCE-OWNERS			22	3	21	0	
4430	WORKMENS COMP INSURANC	61,986		22	3	0	0	
4450	CENTRAL OFFICE FEES	365,758		19	3	34	0	***
4460	BAD DEBTS	19,230		27	3	24	-19,230	
4470	LOST ITEMS-RESIDENTS	1,131		27	3	0	0	
4490	MISCELLANEOUS	0		27	3	0	0	
4510	REAL ESTATE TAXES	0	0	33	3	0	0	
4600	LEASED EQUIPMENT	46,096	46,958	35	3	18	0	
5110	MAINTENANCE SALARIES	51,054	58,449	6	1	0	0	
5120	MAINTENANCE SICK & VAC	7,395		6	1	0	0	
5130	ELECTRIC	44,795	74,501	5	3	0	0	
5131	NATURAL GAS	16,192		5	3	0	0	
5132	HEATING & DIESEL OIL			5	3	0	0	
5133	WATER & SEWER	13,514		5	3	0	0	
5134	TRASH COLLECTION	16,685	126,557	6	3	0	0	
5140	PROPERTY-PLANT REPLACEM	4,858	58,170	6	2	0	0	
5160	GENERAL REPAIR & MAINT	53,312		6	2	0	0	
5165	MAINTENANCE CONTRACTS	112,872		6	3	0	0	
5210	DIETARY WAGES	283,046	302,108	1	1	0	0	
5220	DIETARY SICK & VAC	19,063		1	1	0	0	
5230	DIETARY CONSULTANT	7,512	7,512	2	3	0	0	
5240	FOOD PURCHASES	223,662	223,457	2	2	0	0	
5250	SUPPLIES-DISHWASHING	2,908	19,337	1	2	0	0	
5260	DIETARY REPLACEMENT	2,136		1	2	0	0	
5270	KITCHEN SUPPLIES-PAPER	14,293		1	2	0	0	
5295	MEAL CREDIT	-405		2	2	0	0	
5310	LAUNDRY WAGES	43,222	47,009	4	1	0	0	
5340	LAUNDRY SICK & VAC	3,787		4	1	0	0	
5370	LAUNDRY REPLACEMENT	8,132	12,339	4	2	0	0	
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	
5390	LAUNDRY SUPPLIES	4,207		4	2	0	0	
5410	HOUSEKEEPING WAGES	107,733	112,083	3	1	0	0	
5440	HOUSEKEEPING SICK & VAC	4,350		3	1	0	0	
5480	HOUSEKEEPING SUPPLIES	34,775	34,775	3	2	0	0	
5490	HOUSEKEEPING SUPPLIES-PF	0		3	2	0	0	
6010	RN WAGES-MEDICARE		2,523,051	10	1	0	0	
6020	RN WAGES-NON MEDICARE	510,634		10	1	0	0	
6030	DON WAGES	91,954		10	1	0	0	
6035	ADON	21,199		10	1	0	0	
6040	RN SICK & VACATION	30,958		10	1	0	0	
6110	LPN WAGES-MEDICARE	606,351		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	33,694		10	1	0	0	
6210	AIDE WAGES-MEDICARE			10	1	0	0	
6220	AIDE WAGES-NON MEDICARE	1,118,696		10	1	0	0	
6230	WARD CLERKS			10	1	0	0	
6240	AIDE VACATION & SICK	44,375		10	1	0	0	
6245	CONTRACT NURSES-RN	29,856		10	3	0	0	
6246	CONTRACT NURSES-LPN	8,797		10	3	0	0	
6247	CONTRACT NURSES-AIDES	62,201		10	3	0	0	
6250	NURSE AIDE TRAINING WAGES	2,007	2,007	13	1	0	0	
6255	NURSE AID TRAINING EXP	1,500	-904	13	2	0	0	
6260	NURSE AIDE TRAINING REIMB	-2,404		0	0	0	0	
6270	REHAB WAGES	61,073		10	1	0	0	
6275	REHAB SICK & VAC	4,117		10	1	0	0	
6280	NURSING DEPT EDUCATION			23	3	0	0	
6290	NURSING SUPPLIES	48,964	174,931	10	2	0	0	
6295	NURSING SUPPLIES	120,329		10	2	0	0	
6390	REPLACEMENT-NURSING	5,638		10	2	0	0	
6490	NURSING OTHER	56	108,303	10	3	0	0	
7280	DRUG PURCHASES	277,255	277,359	39	2	0	0	***
7281	DRUG PURCHASES-OTHER	0		39	2			
7380	LABORATORY SERVICES	37,645	37,645	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	133,991	142,879	11	1	0	0	
7540	ACTIVITIES SICK & VAC	8,888		11	1	0	0	
7590	ACTIVITIES SUPPLIES	2,814	2,814	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	315,974	601,374	39	3	0	0	***
7660	PT SUPPLIES	104		39	2	0	0	
7710	SOCIAL SERVICE WAGES	52,343	52,289	12	1	0	0	
7720	SOCIAL SERVICE SICK & VAC	-54		12	1	0	0	
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	
7740	OT FEE	258,267		39	3	0	0	***
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770	SPEECH THERAPY FEE	27,133		39	3	0	0	***
7800	BEAUTICIAN WAGES		0	40	1	0	0	
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	1,623	1,623	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	482,770	482,770	34	3	0	0	
8120	INTEREST EXPENSE	53,444	53,444	32	3	14	-3,045	
8130	DEPRECIATION	0	0	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	
9510	INTEREST INCOME	-3,045		32	0	10	0	
9520	MISC NON-OPERATING INCOM	0		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		7,191,766	7,361,256					
			169,490					
GRAND TOTALS		-142,663					-57,777	
		(NET INCOME)						
		0						

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 162

BALANCE SHEET TOTAL 0

1,009	1,009 CASH	1,319
1,100	1,100 ACCTS RI	500,677
1,101	1,101 ALLOW. F	(368,144)
1,110	1,110 ACCTS RECEIV-MRC	
1,125	1,125 ACCTS RECEIV-IPA	
1,132	1,132 US HHS S	(244,188)
1,140	1,140 UNAPPLIED CASH RECEIPTS	
1,145	1,145 A/R SUSPENSE-REFUNDS	
1,200	1,200 PREPAID	0
1,220	1,220 OTHER PI	1,691
1,300	1,300 DIETARY I	1,869
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 BUILDINGS	0
1,490	1,490 ACCUM DI	0
1,530	1,530 RESIDENT	15,509
1,550	1,550 LOAN FEE	0
1,551	1,551 LOAN FEES ADDED	
1,850	1,850 INTERCOI	25,588
2,010	2,010 ACCOUNT	0
2,100	2,095 BONUSES PAYABLE	
2,100	2,100 ACCRUEI	(110,435)
2,100	2,100 PR CLEARING-BENEFITS	
2,100	2,100 PR CLEARING-LABOR	
2,110	2,110 ACCRUEI	(156,577)
2,120	2,120 U.C. TAXE	0
2,125	2,125 FICA TAXE	(3,697)
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 ACCRUEI	0
2,320	2,320 IPA PAYMI	(13,396)
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	(15,509)
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 RETAINEI	507,956
	net income	(142,663)
	balance	0

3,007	3,007 PATIENT D	6,306
3,007	3,007 PATIENT D	19,240
3,007	3,007 PATIENT D	2,198
3,007		
3,007		
3,007		
3,007		
3,010	3,010 BASIC CH.	(6,556,649)
3,020	3,020 BASIC CH.	0
3,030	3,030 BASIC CH.	0
3,040	ASSESSM	166,445
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING	(13,200)
3,081	3,081 NURSING	0
3,082	3,082 NURSING	0
3,083	3,083 NURSING	0
3,100	3,100 DRUGS-M	(467,897)
3,101		0
3,110	3,110 PHYSICAL	(1,888,255)
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 THI	0
3,153	3,153 ST/OT THI	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTHEI	0
3,411	3,411 MEDICARI	0
3,420	3,420 MEDICARI	1,844,633
3,452	3,452 HHS STIMI	(427,964)
3,520	3,520 RENT INCI	6
3,530	3,530 BEAUTY S	(2,713)
3,560		0
3,570	3,570 VENDING	(90)
3,580	3,580 EQUIPMEN	(2,748)
3,595	3,595 RESIDENT	(12,093)
3,600	3,600 MISC INC	(11)
4,110	4,110 G&A WAG	232,815
4,111	4,111 ADMINISTR	103,055
4,115	4,115 G&A PTO	26,885
4,121		0
4,130	4,130 EMPLOYE	6,340
4,135	4,135 EMPLOYE	(14,425)
4,250	4,250 OFFICE S	8,633
4,255	4,255 POSTAGE	3,529
4,260	4,260 TELEPHO	11,294
4,275	4,275 TRAINING	652
4,279		0
4,280	4,280 GENERAL	2,263
4,281	4,281 MEAL EXP	0
4,285	4,285 EDUCATI	0
4,289	4,289 MEETINGS	0
4,290	4,290 HELP WAI	14,289
4,291	4,291 PROMOTI	22,060
4,292	4,292 PUBLIC R	2,765
4,300	4,300 LICENSE	59,457
4,310	4,310 DUES & S	9,014
4,320	4,320 CONTRIBI	(30)
4,330	4,330 PROFESSI	6,211
4,350	4,350 MEDICAL I	12,000
4,362		736
4,363		6,657
4,364	4,364 SOCIAL SI	1,795
4,370	4,370 TV RENTA	14,862
4,380	4,380 BACKGRC	2,765
4,390	4,390 OTHER TA	0
4,400	4,400 PAYROLL	287,822
4,401	4,401 PAYROLL	0
4,410	4,410 GROUP IN	126,786
4,420	4,420 LIABILITY I	62,815
4,430	4,430 WORKMAI	58,125
4,435	4,435 W/C-FIRS	44
4,436	4,436 DRUG TE	3,817
4,450	4,450 MANAGEM	365,758
4,460	4,460 BAD DEBT	19,230
4,461	4,461 BAD DEBT	26,340
4,470	4,470 LOST ITEI	1,131
4,475	4,475 UNIFORM	215
4,486	4,486 SERVICE	76,013
4,490	4,490 MISC EXP	265
4,498	4,498 MISC. NU	10,264
4,510	4,510 REAL EST	0
4,600	4,600 LEASED E	46,096
5,110	5,110 MAINTENA	51,054
5,120	5,120 MAINTENA	7,395
5,130	5,130 ELECTRIC	44,795
5,131	5,131 NATURAL	16,192
5,133	5,133 WATER &	13,514
5,134	5,134 TRASH C	16,685
5,140	5,140 PROP PL/	4,858
5,160	5,160 GENERAL	53,312
5,165	5,165 MAINTENA	36,859
5,210	5,210 DIETARY	283,046
5,220	5,220 DIETARY	19,063
5,248	5,248 FOOD PUI	223,597
5,250	5,250 SUPPLIES	2,908
5,260	5,260 REPLACE	2,136
5,270	5,270 KITCHEN S	14,293
5,295	5,295 MEAL INC	(405)
5,310	5,310 LAUNDRY	43,222
5,340	5,340 LAUNDRY	3,787
5,370	5,370 REPLACE	8,132
5,230	5,230 DIETARY C	7,512
5,390	5,390 LAUNDRY	4,207
5,410	5,410 HOUSEKE	107,733
5,440	5,440 HOUSEKE	4,350
5,480	5,480 SUPPLIES	34,775
5,490	5,490 SUPPLIES	0
6,020	6,020 RN WAGE	510,634
6,030	6,030 DON WAG	91,954
6,035	6,035 ADON WA	21,199
6,040	6,040 RN PTO &	30,958
6,120	6,120 LPN WAGI	606,351
6,140	6,140 LPN PTO	33,694
6,220	6,220 AIDES WA	1,118,696
6,240	6,240 AIDES PT	44,375
6,245	RN CONTI	29,856
6,246	LPN CONT	8,797
6,247	AIDES CO	62,201
6,250		2,007
6,255		1,500
6,260		(2,404)
6,270	6,270 REHAB W.	61,073
6,275	6,275 REHAB PT	4,117
6,290	6,290 NURSING	48,964
6,295	6,295 NURSING	120,329
6,390	6,390 REPLACE	5,638
6,490	6,490 OTHER	56
7,280	7,280 DRUG PUI	277,255
7,281	7,281 DRUG PUI	0
7,380	7,380 LABORAT	19,901
7,391	7,390 X-RAY SEI	10,729
7,393		7,015
7,510	7,510 ACTIVITIES	133,991
7,540	7,540 ACTIVITIES	8,888
7,590	7,590 ACTIVITIES	2,814
7,620	7,620 PHYSICAL	315,974
7,660	7,660 P.T. SUPP	104
7,710	7,710 SOCIAL SI	52,343
7,720	7,720 SOCIAL SI	(54)
7,730	7,730 SOCIAL SI	0
7,740	7,740 OCCUPAT	258,267
7,750		
7,770	7,770 SPEECH T	27,133
7,820	7,820 BEAUTICIA	1,623
7,890		0
7,960		0
8,120	8,120 INTEREST	0
8,125		53,444
8,130	8,130 DEPRECIA	0
8,150		0
9,510	9,510 INTEREST	(3,045)
9,520	9,520 MISC NON	0
9,530	4,220	0
	8,100	482,770
	9,702	0
	5,230	0
		(142,663)

Expenses Fixed Assets

0

Heritage Manor - Chillicothe
IDPH ID# 48868
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	$	277,255
Purchased Hospital Services		13,315
Purchased Laboratory Services		19,901
Purchased Radiology Services		4,429
Amount Reclassified to Line 39	$	314,900

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

Line Item		
Provider Participation Fee - $1.50	$	(58,194)
Provider Assesment Fee - $6.07		(166,445)
		(224,639)
Provider Participation Fee		224,639

3. Schedule V - Line 10 to Line 10a - Reclass Pharmacy Consulting Fees

Line Item		
Pharmacy Consulting Fees	$	6,657